
HEALTH-PRO PHYSICAL THERAPY, INC.

110 La Casa Via, Suite 100, Walnut Creek, CA 94598
Phone: 925-935-4866 Fax: 925-935-8873

Welcome to Health-Pro Physical Therapy, Inc.

We hope your experience at our clinic will be a positive one. Please feel free to contact us for any questions or concerns, or if you have a problem regarding any aspect of our service. We can be reached at **925-935-4866**.

Contacts: Sandy Schall, PT, Owner/President/Clinical Director
Randi, Clinical Coordinator
Stephanie, Billing/Collections Coordinator
Megan Thomas, PTA, Assistant Clinical Director

Scheduling/Office Policies

APPOINTMENTS: We are open Monday through Friday, including early morning, late evening and lunchtime, as well as some Saturday mornings. We will make every effort to accommodate your needs. Please schedule out your whole prescription if possible, to allow you better choices of times available. **Please arrive at least 20 minutes prior to a new evaluation, and 5 minutes prior to all follow-up appointments.** We try hard to stay on time and on schedule. If you are going to be late please call and notify our office as soon as possible. If you are more than 15 minutes late to your scheduled appointment, your appointment may be rescheduled at the discretion of the treating therapist, and a missed visit charge of \$75 may apply. This fee CANNOT be charged to your insurance carrier.

Unfortunately, the unpredictability of our patients' needs will sometimes cause delays in the office. Please bear with us. We will give you the same care and consideration during your treatment. If you have a tight schedule, please let the front desk know and we will try to accommodate you.

It is very important to your recovery to attend therapy regularly as prescribed and perform your home program as instructed. Please understand that your pain may increase or decrease as your course of treatment progresses and before it is finally erased. Please notify your therapist of any changes in your symptoms, either better or worse, so your treatment plan can be modified or progressed as needed.

CANCELLATIONS or MISSED APPOINTMENTS: If you have to cancel or reschedule an appointment, please give 24 hours notice if possible. A \$75 fee will be charged on visits missed or cancelled without 24 hours notice. This fee CANNOT be charged to your insurance carrier. Your first visit will be reserved with a credit card, which will be charged the \$75 fee if you miss without notifying our office. It is the patient's responsibility, when he or she calls in, to have an alternative time in mind that will ensure they get in the full prescribed number of treatments that week whenever possible. It may be necessary to see a therapist other than your regular therapist if you have to reschedule an appointment. If you have more than two no shows and/or multiple cancellations, any future appointments may be automatically cancelled and those times given to other patients. Also, missing appointments may adversely affect your response to treatment. Please be aware that if you are a workers' compensation patient, multiple no shows and cancellations may possibly jeopardize your continued treatment and claim, as this may be a sign of non-compliance to your carrier.

CLOTHING: Please wear comfortable clothing such as sweatpants, shorts, t-shirts or other clothing that allows freedom of movement. We have gowns and shorts available for you to use if needed.

OVER

Financial and Billing Policies

Our office is pleased to accept your insurance assignment. If you have insurance, we bill your participating insurance company as a courtesy but ultimately, the patient or policy holder is the primary person responsible for the bill. Please provide us with all the necessary information to enable us to bill your current insurance carrier(s) for you. We require a copy of the front and back of your insurance cards(s) as well as a copy of a picture ID for identity verification. To assure continuous coverage, whenever your insurance changes you must notify us prior to your next visit or when you schedule and appointment, as we will need copies of your new card, and we will need to verify your new coverage.

Before your first visit, Health-Pro Physical Therapy, Inc. verifies your eligibility, deductible and co-pay information directly with your insurance company. Please refer to the insurance verification form you will sign before your initial visit. If you feel that your insurance company for any reason has misinformed us, please call them. Verification of coverage is not a guarantee of coverage. We will make every attempt to provide the insurance with the required information for them to pay your claim, however, if for some reason your insurance claim is denied, you are responsible for the bill. It is the responsibility of the policy holder to be aware of individual policy benefits and limitations.

Our billing goes out daily. If we have not received payment from your insurance company after 30 days from the date of services, we will re-bill your carrier one time for each unpaid date. If we have not received payment after 90 days from the initial dates of services, you will become responsible for the bill. If the insurance pays Health-Pro Physical Therapy for the date(s) in question after that time, you will be reimbursed. Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.

We send out patient balance statements at various times throughout treatment and the collections period, if indicated. Please let our office know immediately of any concerns about your bill. Payment is due no later than 30 days from the date of the statement unless otherwise stated. If you need to make payment arrangements for your balance, please contact our billing coordinator for a payment plan. If your check is returned by the bank due to insufficient funds, there will be an additional \$25.00 charge added to your account to cover bank fees and rebilling. If your account has a balance due that is not paid in full within the 30 day time frame from the date of the first statement, Health-Pro Physical Therapy may charge a \$5.00 rebilling fee for each subsequent statement. This \$5.00 fee also applies to payment plan statements if an automatic debit option is not chosen. If your account becomes delinquent and is referred to a collections agency, an additional administrative fee of \$50.00 will be applied to your account to cover costs. Your credit card information provided to reserve your first visit will be kept on file for future reference, and may be billed if your account becomes delinquent, before your account is submitted to our collections agency. A \$25 fee will be assessed for records request.

CO-PAYS/CO-INSURANCE/DEDUCTIBLES: Co-pays are due at the time of your visit and should be paid at the front desk after signing in, and before your appointment. For most major insurances, we will collect your calculated co-insurance and/or deductible at the following visit(s). If your insurance pays a flat rate for services, the coinsurance and/or deductible amount will be collected on the date of service. If there is a difference in the amount collected and the patient responsibility amount stated on your explanation of benefits for that date of service, your account will be corrected and the additional amount billed, credited or refunded as indicated. For other insurances, once your insurance has made payment on specific dates of service, we send out a patient statement if there is a patient balance due for those dates. We accept Visa, MasterCard, Discover, American Express, personal checks and cash for co-pays and any other payments you make on your account. If we need to bill you for a co-pay, we may charge an additional billing fee of \$5.00. We have an easy pay program available for setting up automatic payments for those patients with recurring charges who choose to use this service. We also encourage this program when a payment plan is established. Overpayments on accounts will be refunded upon written request within 30 days of our office confirmation.

I have read and understand the policies as outlined above. I understand that by signing this form I am accepting financial responsibility as explained for all payment for products/services received. I understand my financial responsibility as a patient.

Signature of Patient/Policy Holder/Legal Guardian: _____ Date: _____

Print Patient Name: _____