CONEJO VALLEY PHYSICAL THERAPY CVPT
...BRINGING MOTION TO LIFE!

Financial Policy Statement

Dear Patient,

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 90 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

If any payment is mailed directly to you for services billed by us, you recognize an obligation to promptly remit same to CONEJO VALLEY PHYSICAL THERAPY. The payment and explanation of benefits will be made in your name.

The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

CANCELLATION OF APPOINTMENTS WITHOUT 24 HOUR NOTICE WILL RESULT IN A $50 CANCELLATION FEE. (this does not apply to Gold Coast members)

GOLD COAST members will receive one "warning", if there is any cancellation after this warning, patients will be put on a call in basis

Los miembros de GOLD COAST recibirán una "advertencia", si hay alguna cancelación después de esta advertencia, los pacientes serán puestos en una llamada en base

ESTIMATED INSURANCE BENEFITS:_____

ESTIMATED PATIENT PAYMENT**:**_____

Note: Estimated coverage information is provided as a courtesy to our patients and is not a guarantee of payment.

The above information has been read and explained to me. I understand my responsibility for the payment of my account.

_____ _____

Patient/Guardian Signature Date

_____

Witness Signature