Financial Policy

New Heights Performance Physical Therapy will assist the patient or the responsible party of the account by filing insurance when requested, but the level of reimbursement for services is a matter between the insurance company and the patient. Mendota Physical Therapy, DBA New Heights Performance Physical Therapy is contracted with all major insurance providers. Please note, patient responsibility will depend on in or out of network benefits. Please check your physical therapy benefits with your insurance provider. The patient or the responsible party is accountable for any charges not covered by insurance, which may include co-payments, co-insurance and deductibles. Co-payments are due at the time of service. If you opt not to bill your insurance, a discounted cash rate is available. Initial: ________

A patient that does not have insurance coverage, or verifiable insurance coverage will be expected to pay in full at the time of service, or until insurance coverage has been obtained or verified.

All balances are due and payable within 30 days of the billing date. An account is considered past due after 60 days. Methods of payment accepted are cash, check, money order, Visa, Mastercard, Discover and American Express. Any checks that are returned from the bank for non-payment are subject to an additional fee.

Requested exceptions to this policy must be made in advance of any scheduled clinic visit or provision of service with the exception of an emergency.

For patients that have insurance coverage that require a referral, it is the patient's responsibility to obtain the required referral prior to the scheduled visit.

New Heights Performance Physical Therapy reserves the right to request from the patient, or responsible party of the account, verification of their insurance coverage at each clinic visit. In addition, we may also request that you review and if appropriate, update pertinent patient and billing information (Mailing address, telephone number).

Please inform New Heights Performance Physical Therapy if you have received therapy services elsewhere this year.

I acknowledge that I have read and understand the provisions of the financial policy.

Print Patient Name:____ Date:________

Print Responsible Party Name: ____

Responsible Party Signature: ____