

Sterling Therapy & Rehabilitation, PLLC

Financial Policy and Patient Responsibility

Sterling Physical Therapy & Rehabilitation, PLLC is committed to providing our patients with the highest quality care. We thank you for taking the time to read and understand our policy.

It is the Patients Responsibility:

- **To know their insurance policy. Patients should be aware of their benefit coverage including which healthcare providers are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, coinsurance, and co-payments. If you are not familiar with your plan coverage, we recommend you contact your carrier directly.**
- **To obtain a referral from their Primary Care Provider (PCP) and/or obtain authorization for treatment form their insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.**
- **To pay their co-payment at the time of service.**
- **To pay any Medicare deductible and co-insurance amounts not covered by supplemental insurance.**
- **To promptly pay any patient responsibility indicated by their insurance carrier.**
- **To facilitate in claims by payment by contacting their insurance carrier when**

It is Sterling Therapy & Rehabilitation, PLLC's responsibility:

- **To provide quality medical care.**
- **To file insurance claims as a courtesy to the patient. A 60 day period will be extended for pending insurance payment, after which the patient may be held responsible for the balance.**

Financial Policy Acknowledgment:

I have read and understand the above financial policy. I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered.

Patient or Responsible Party Signature

_____/_____/_____
Date

Release of Medical Information and Assignment of Benefits:

I authorize the release of medical information necessary for filing health insurance claims for me by Sterling Physical Therapy. I also authorize my insurance carrier(s) to make payment directly to Sterling Physical Therapy.

Patient or Responsible Party Signature

_____/_____/_____
Date