

**Pro Motion Physical Therapy, LLC**  
6849 Old Dominion Drive, Suite 221  
McLean, Virginia 22101  
(703) 848-9333 • Fax (703) 848-0660

**CLINIC AND PATIENT FINANCIAL TERMS**

Welcome to Pro Motion Physical Therapy, LLC! We are dedicated to providing the best possible physical therapy service and care to you and regard your complete understanding of our financial policies as an essential element of your care and treatment. We want to assure that this process is as smooth as possible so that we can focus on our primary concern...your health.

**Billing Information**

*Pro Motion Physical Therapy, LLC does not participate with any insurance companies other than Medicare and Blue Cross /Blue Shield PPO. We would like to extend the courtesy of billing your insurance company for you. However, we do ask that you pay all co-pays, deductibles, and non-covered charges the day of your service.*

- We must emphasize, as your physical therapy provider, our relationship is with you and not your insurance company.
- While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the dates the services are rendered. If your insurance company does not pay Pro Motion Physical Therapy within a reasonable period, we will have to look to you for payment. We will accept Visa, Mastercard, cash, or check. There is a service fee of \$25.00 for all returned checks.
- All insurance plans are not the same and do not cover the same services. In the event your insurance plan determines a service to be “not covered”, or you do not have the appropriate authorization or referral, you will be responsible for the complete charge. We will attempt to verify benefits prior to your visit; however, ultimately, you remain responsible for charges on services rendered. You are encouraged to contact your insurance company to verify your benefits and assure that your claims are being processed properly.
- We do not submit claims to third party payers. We will extend the courtesy of submitting claims to your health insurance and it is your responsibility to then file with the third party payer. In the event that your health insurance does not pay, you will be responsible for any remaining balance of payment on your account.
- All past due accounts are subject to collection proceedings. All fees including, but not limited to, collection fees, attorney fees, and court fees shall become your responsibility in addition to the balance due to this office. By signing below I am agreeing to be responsible for all cost incurred in the collection of my account.
- All accounts that are 90 days past due will be subject to interest at 1.5 percent.
- **A \$50.00 fee will be charged to your account for appointments cancelled without 24 hour prior notice.** This fee is not billable to your insurance company and is your responsibility. We appreciate your respect for other patients who can utilize your reserved time.

**Appointment Information**

- Your insurance company may require a referral by a physician. This referral should be provided to us on your initial (evaluation) visit to our clinic.
- It is also your responsibility to monitor the number of authorized visits for physical therapy. Frequently, an insurance company will deny payment if the referral is not current or the authorized visits have been exceeded.
- The initial visit will usually last 60 minutes with all subsequent sessions lasting approximately 45-60 minutes.
- Please arrive promptly for each scheduled appointment. Your therapist may be prevented from providing a full treatment if you are more than 15 minutes late.
- Please call at least 24 hours in advance to cancel or change an appointment.

**Acknowledgement**

I have read and understand all of the above information, and agree to abide by all of its terms and conditions. I hereby authorize the release of any information, including medical information, requested by the insurance company for this or any related claim for reimbursement and authorize payment by such insurance company to Pro Motion Physical Therapy, L.L.C. for services rendered. Further, I understand that I am personally responsible for all charges not covered by my insurance company.

Signed \_\_\_\_\_ Date \_\_\_\_\_