Patient Financial Responsibility

It is the policy of this office to help keep your health care costs as low as possible. In order to do this, we need to keep our billing costs to a minimum. Please help us in the following ways:

- Always bring your current health insurance card to the office
- Please notify us at appointment of any changes in insurance, address, phone #, etc.
- Please pay for your copayment on day of service; or if you do not have insurance, please come prepared to pay for your visit in full.
- You should receive a bill for any patient responsibility within 30 days; and/or an explanation of benefits from your insurance carrier. If you do not, please contact our office.

Payments: Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued.

Payment options if you have insurance: We are required by insurance contracts to collect all copayments.

Private Pay: For your convenience we accept cash and credit card on the day treatment is provided.

Insurance: It is the responsibility of the cardholder to know what the eligibility and coverage is with their insurance carrier. If this is not known, it is suggested the cardholder verify coverage limitations prior to the appointment date. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of eligibility. You are responsible to notify us of any changes in your insurance. Please bring in updated information to your visit, fax to 509-207-7427 or email to office@icantherapy.us. You agree to pay any portion not covered by your insurance.

Separated parents: The parent authorizing the treatment for a child will be the parent responsible for subsequent charges. If a court decree requires another party to pay all or part of the treatment cost, it is the authorizing parent's responsibility to collect the fees.

Waiver of Confidentiality: You understand if the account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past-due status is reported to a collection agency, the fact that you received treatment at our office may become a matter of public record.

Having read the about financial information, I request services to be performed. I also agree to be ultimately responsible for charges incurred for the patient.

Patient's Signature:_____ Date:_____

Parent/Guardian Signature: _____ Date:_____
(If under 18)

Print Name:_____