

**PT PLUS MANAGEMENT CORPORATION POLICIES**

*Welcome to PT Plus! We appreciate the confidence you have placed in us to meet your rehabilitative needs. Please review and sign the following policies, which will assist us in providing you a pleasant and successful experience at PT Plus.*

**Financial Policy** – We will bill your insurance as a courtesy to you. PT Plus is in most, but not all insurance plans. We will work with you to determine your benefits. We encourage you to PLEASE contact your insurance company to verify these benefits. You are ultimately responsible for all charges incurred for treatment at PT Plus.

All co-pays are required at time of service. The co-payment can not be waived by our practice, as it is requirement placed on you by your insurance company.

For patients who do not have insurance coverage, or who have exhausted benefits, we do offer a cash rate. This must be paid at time of service. Cash-pay services can not be billed to your insurance.

Our Central Billing Office will bill you for any co-insurance and deductible amounts after your insurance company has processed your claims. All balances are due within 30 days. We accept cash, checks, MasterCard, Visa, and Discover. A \$35.00 fee will be placed on all returned checks.

**If your account becomes delinquent and must be turned over to a collection agency, you agree to be liable for any reasonable attorney fees, collection agency fees, and court costs incurred to collect the debt.**

Please make sure our billing office has all of your current information.....this is your responsibility.

Please contact our billing office with any questions or concerns:

PT Plus Management Corp.  
1139 S. Sunnyslope Dr. #203  
Racine, WI 53406  
PH: 262-321-0240 Fax: 262-321-0242

**If this is a workers compensation injury, auto accident, or personal injury case, you must fill out a specific form. Please communicate this to us at your initial visit. It is also your responsibility to give us the name and address of any attorneys that you may have retained. We will require a letter of protection.**

**Financial Hardship** – We are in the business of helping people. Should you have some difficulty in paying your bills, please contact our billing office. We will work with you to develop a payment plan. You will be asked to complete and sign our Financial Hardship form.

**Appointment/Cancellation Policy** – Consistent attendance is important to meeting your goals of therapy. We realize there are times when unforeseen circumstances make it impossible to attend your scheduled appointment. We kindly ask you for a **24 hour** notice for cancelling and rescheduling appointments. Following two “no call/no show” appointments, based on the decision of your therapist, you will either:

- Be charged \$50.00 per no show prior to being rescheduled, or
- Be discharged from physical therapy

If you are more than 10 minutes late, we will require you to reschedule or wait for the next opening. We attempt to not overlap appointment times, as it may compromise patient care.

**By signing below, I certify that I have read the above policies, understand them, and will comply.**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Signature of Patient or Guardian** **Date**

**COPY GIVEN TO PATIENT: YES / NO DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ INITIALS: \_\_\_\_\_**