



Payment Policies

Welcome to Athens Therapeutics Physical Therapy Services

Please take a minute to review our payment policies. Our receptionist or office manager will be happy to answer any questions you have.

Payment Policies

All charges that you incur at our office are your personal responsibility to pay. You may pay for your charges in full at each visit (and pursue your own reimbursement if desired) or choose to use our third party payer filing service. There is no extra cost to use this service, however, you must agree to the following terms:

Your third party payer benefits will be verified before or soon after your first visit but ultimately you are responsible for understanding the terms of your policy. You will be required to pay any unmet deductible and subsequently, any co-payment or co-insurance amounts per your third party payer policy. We request that you pay your co-payment and/or your co-insurance amounts each visit.

All amounts that you pay to Athens Therapeutics are considered deposits against your outstanding balance. No refunds will be made as long as you have an unpaid balance on your account. Refunds will only be made when you have a credit balance. This normally occurs after your treatment has been completed and all payments from your third party payer have been received.

You agree not file any claims directly. You must inform us immediately of any change in your insurance coverage. Your third party payer must allow you to have reimbursement payments sent directly to our office. If your third party payer does not allow this we require that you pay for all treatment at the time of your visit.

We will notify you of any charges that your third party payer declines to pay and ask that you make payments to our office in a timely manner. **We will bill your third party payer every week and use our best efforts to obtain payment. However, any charges that remain unpaid 60 days after billing become your personal responsibility to pay.**

Initial One:

_____ I would like to use this office’s third party payer filing service and agree to the terms listed above.

_____ I prefer to file my own third party payer claims and will pay this office in full at each visit.

I have read and understood Athens Therapeutics Payment Policies.

Signature: _____ Date: _____

If you are choosing to use this office’s third party payer filing service, please read and sign below:

I hereby accept full financial responsibility for charges incurred for services rendered at this office. I authorize the office of Athens Therapeutics to affix my name to any and all claims or documents as related to any and all health benefits due to me and my dependents. I authorize the release of any medical or other information necessary to process a claim requesting payment be made to the provider of service. I hereby authorize payment of medical benefits otherwise payable to be irrevocably assigned to the provider of service. I understand that services are rendered and charged to the patient and not to the third party payer. I acknowledge that this office cannot accept responsibility for collecting an unpaid third party claim or negotiating a disputed settlement. I also agree that this obligation shall exist regardless of private contractual agreement between myself and any third party payer, attorney, or other third party not signing this agreement.

Signature: _____ **Date:** _____