Orthopedic and Spine Center

Theraplay LLC

4651 W Vernal Pike Bloomington, IN 47404

Phone : (812) 332-7529 Fax: (812) 339-7529 Email: customerservice@theraplayspine.com

Billing & Collections Policy

Thank you for choosing us as your Physical Therapy care provider. We are committed to providing you with quality and affordable physical therapy care. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Copayments, coinsurance and deductible. Should be established and verified prior to beginning the PT Program. All copayments, coinsurance & deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company.
High Deductible, Set PT payment for the following Insurances.

- $80.00 (United Healthcare, UMR, & Golden Rule)
- $85.00 (Cigna, NALC, & APWU)
- $50.00 for any other insurances

Non-covered services. Please be aware that some and perhaps all of the services you receive may be non covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of service (Self Pay & Supplies).

Proof of insurance. All patients must complete our patient information form before starting any Physical Therapy Program. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. Failure to provide us with the correct insurance information in a timely manner, means you may be responsible for the balance of a claim.

Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays

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your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Nonpayment. If your account is over 60 days past due, you will receive a letter stating that you have 20-30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.(NO SHOW POLICY)

Self Pay Option. The cash-based billing model is used to simplify the patient experience. At an affordable flat rate, we want to provide the best services or treatment to address health and wellness needs. Please request a copy of the Private Pay Policy for further information.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Patient Name or Responsible Party	Signature	Date
______________________________	________________________	_________________