Wasatch Physical Therapy

Financial Policy

Wasatch Therapy will bill medical claims to the insurance company if we have been provided the correct information. Your insurance is a contract between you, your employer (if applicable), and your insurance company. We are not a party to that contract. Therefore, it is the patient's responsibility to determine what their insurance company allows for therapy, what the insurance requirements are, and follow up with the insurance company on all unpaid visits. **Co-payments and self-pay amounts are due at the beginning of each visit.** If you have not met your deductible, the copay amount will be applied to the deductible and you will be billed for the remaining amount.

Should your insurance deny payment or coverage for any reason, you are responsible for any and all charges billed.

If you are working with an attorney or your insurance denies payment due to your injury being work or auto related, you are responsible for the balance on the account. Wasatch Therapy only accepts liens through specific companies and we do not hold accounts until your claim is settled.

All delinquent accounts will be charged an interest rate of 1.5% per month (18% per annum). In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee and all costs of collection. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney fees. You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages, or emails, using any email you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

By signing below, I agree to all of the above. I agree that it is and shall remain my responsibility to pay all amounts owing. The terms of this agreement shall apply to all amounts incurred by me or by any individual for whom I have legal responsibility whether such amounts are incurred today or after today.

_____	_____	_____
(Patient Name)	(Signature of Patient or Authorized Representative)	(Date)

Please choose how you would like to receive your billing statements:
(The mailing address, email, or cell phone number you have provided will be used to sent your statement. Please verify we have the correct information.)

_____ I would like to receive my billing statement with a payment link by **text**.
_____ I would like to receive my billing statement with a payment link by **email**.
_____ I would like to receive my statements in the **mail**.

Contact information if different than previously provided: _____

HIPAA Patient Consent

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice of Privacy Practices before signing this Consent.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. We provide this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____	_____	_____
Patient Name	Signature of Patient or Authorized Representative	Date