Blaire Zikratch, DPT ATC PT-2831
151 N. 4th. Ave. Ste. A Pocatello, ID 83201
Phone 208-637-2225 Fax 208-258-7389
reception@streamlinesportspt.com

FINANCIAL AGREEMENT/POLICY

Thank you for choosing Streamline Sports for assisting you with your health care needs. We are committed to provide the very best care and successful treatment. The following is a statement of our financial policy, which you must read, agree to, and sign prior to treatment. This financial policy applies to any and all services rendered by Streamline Sports and its staff.

Proof of Identification

The patient is required to provide a picture ID. A photo will be taken or you may choose to use copy of a valid state issued driver's license. If you are underage, your legal guardian must provide this information.

Practice Payment Policy Guidelines

1. Patients/Guardians are financially responsible for all charges, regardless of third-party involvement.
2. Full payment is due at the time of service, unless billing arrangements have been made.
3. Patients with insurance are required to pay for all "out of pocket" financial obligations at the time of service.
4. We accept cash, Visa, MC, Discover, Debit cards and Checks. There will be a $35.00 service charge for all returned checks.

Patient Responsibilities and Financial Policies-PLEASE INITIAL THAT YOU HAVE READ AND AGREE TO EACH ONE

_____ *Provide accurate information:* You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance, and other billing information. If any information changes, you must inform this office immediately. Insurance denials or billing errors due to patient supplied information or misinformation will result in the transfer to the patient account balance of the patient's immediate financial responsibility.

_____ *Know your insurance coverage, benefits, and referral requirements:* Your health insurance is a contract between you and your health insurance plan(s). Patients are responsible for understanding their health insurance coverage, benefits, and referral requirements to receive treatment, diagnostics and therapeutic services from this practice. **Patients are responsible for securing the necessary written referral, pre-authorization, or pre-certification from your primary care physician or health plan prior to your appointment**, **otherwise the appointment may be rescheduled, or you will be personally responsible for payment of services that day**. Please present your Insurance ID card to our staff upon registration/sign in.

_____ Patients with Private Insurance: The physicians of Streamline Sports participate with some insurance company health plans, but not all. **It is the patient's responsibility to verify our participation with your Insurance.** This office will file claims with your insurance company provided you authorize the "assignment of benefits" below for payment directly to this practice. For participating insurance plans, this office will accept payment based upon contractual agreements. For plans in which Streamline Sports care providers do not participate, payment dispute is a matter between the policy holder and the insurance company.

_____ To summarize your financial responsibility, you are 100% responsible for denied and non-covered services, services deemed "not medically necessary" by your insurance carrier, copays, deductibles, and/or out-of-network benefits. As a courtesy, payment plans are available for you and your family. We understand the higher costs of healthcare these days so we have a payment plan that will fit your budget. If your situation requires special consideration, please let us know. ***All insurance checks and payments will be assigned to our office.*** If you mistakenly receive an insurance check in your mail, please bring the check and all attached paperwork to our office so that we may properly credit your account.

_____I, the undersigned, agree to pay all attorneys' fees, court costs, filing fees, including charges or commissions that may be assessed to me by any collection agency retained to pursue such matters as allowable by law. Further agree to pay interest in the amount of 1.5% per month on any balance over 90 days.

I have read, understand and agree to this financial Policy in its entirety and give Streamline Sports permission to furnish my insurance carrier(s) any and all information pertaining to my medical records.

X_____ _____ _____

Printed Name of Patient **Signature of Patient/Responsible Party/Parent/Guardian** **Date**