



# mondo

## Sports Therapy

### Patient Payment Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist or the Practice Manager.

#### How May I Pay?

We accept payment by cash, check, VISA, Mastercard and Discover.

#### What Is My Financial Responsibility for Services?

Your financial responsibility depends on a variety of factors, explained below.

### Office Visits

If You Have...	You Are Responsible For...	Our Staff Will...
<b>Commercial Insurance</b> Also known as indemnity, "regular" insurance	Payment of the patient responsibility for all office visit, x-ray, injection, and other charges at the time of office visit.	Call your insurance company ahead of time to determine deductibles and coinsurance. File an insurance claim as a courtesy to you.
<b>HMO &amp; PPO plans with which we have a contract</b>	<u>If the services you receive are covered by the plan:</u> All applicable copays and deductibles are requested at the time of the office visit. <u>If the services you receive are not covered by the plan:</u> Payment in full is requested at the time of the visit.	Call your insurance company ahead of time to determine copays, deductibles, and non-covered services for you & file an insurance claim on your behalf.
<b>HMO with which we are <u>not contracted.</u></b>	Payment in full for office visits, x-ray, injections, and other charges at the time of office visit.	Provide the necessary information for you to complete and file your claim directly with the insurance company.
<b>Point of Service Plan or Out Of Network PPO</b>	Payment of the patient responsibility—deductible, copay, non-covered services—at the time of the visit.	Call your insurance company ahead of time to determine out of network benefits, copays, deductibles, and non-covered services & file an insurance claim on your behalf.
<b>Appointment No Show</b>	Letting us know 24 hours in advance if you can't make an office appointment. Paying a \$35 administrative fee if you aren't able to cancel 24 hours in advance.	Confirm your appointment the 1-2 days in advance of your appointment.
<b>No Insurance</b>	Payment in full at the time of the visit.	Work with you to settle your account. Please ask to speak with our staff if you need assistance.

- *I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.*
- *I authorize my insurance benefits be paid directly to **Mondo Sports Therapy**.*
- *I authorize **Mondo Sports Therapy** to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name