



3645 Gention Blvd, Suite 1
Columbus, GA 31907

PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY SERVICES

PATIENT PAYMENT POLICIES

Dear Patient:

We would like to take this opportunity to welcome you to our office. Our staff is here to help you achieve a speedy and full recovery. Patients are referred by physicians, dentists, podiatrists, doctors of osteopathy, and chiropractors. All patients are evaluated by a licensed professional. An individualized program is then designed to suit your particular needs. We are in continuous contact with your physician to keep him/her abreast of your progress. We utilize the holistic approach to wellness by involving you, the physician, and the therapist working together as a team for your recovery.

As you have come to us by referral of your physician, you undoubtedly may have questions regarding your physical therapy treatment as well as the cost of treatment. Please take the time to read the following policy statements to familiarize yourself with the policies of this office. Should you have any questions, feel free to ask the office manager or receptionist. Specific questions about your therapy should be directed to your therapist.

PAYMENT POLICY

As a courtesy to our patients, we will verify and file your insurance. However, we cannot guarantee payment. We suggest that you read your policy manual pertaining to physical therapy coverage. Many insurance companies have stipulations, such as usual and customary fees, limited therapy sessions, a limited to the amount paid per session, deductibles, co-payments, supplies, etc. These should be listed in your policy manual. You are responsible for amounts not covered. We have an agreement with you and not your insurance company for payment. Please be aware of this and plan to make payments accordingly. Workers' Compensation coverage will be verified. However, this does not guarantee payment. IN THE EVENT OF DENIAL, THIS ACCOUNT WILL BECOME YOUR RESPONSIBILITY.

We appreciate that you and your physician have chosen R & R Rehabilitation to provide all of your physical, occupational, and speech therapy needs.

Signature of Patient: _____ Date _____