RIW
Rehabilitation Institute of Washington PLLC

Financial Agreement

Financial Agreement: As a courtesy, we will submit a claim for our services to your insurance company. You are responsible for payment of any deductibles, co-payments, and/or patient portions at the time services are rendered. If your account becomes past due (30 days from notification of balance), you may be charged interest at a rate of 1.0% per month. Balances more than 120 days past due will be considered delinquent, and subject to collection activity. **While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered.**

Workers Compensation: *We will pre-authorize and bill as required to the State of Washington or Self Insured Claims Administrator. You will not be billed for any services relating to an open and allowed claim; however you may be responsible if you seek care under a closed or disallowed claim, or for services not related to your industrial injury.*

Motor Vehicle Accident / MVA: *RIW will gladly send a bill to your insurance company or other payer for services provided. Due to the uncertainty of payment in MVA claims, if the charges are denied or otherwise not paid, the patient or responsible party agrees to pay the charges for services provided. We do not provide services where payment is contingent on outcome of litigation.*

Preauthorization Requirements: It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements. We will, however, assist you to ensure that all plan requirements are met. At your request, we can verify insurance coverage and benefits; however any summary of benefits we receive from your insurance company is not a guarantee of payment.

Returned checks will result in a $25 fee that will be posted to your account. Returned checks, balances older than 120 days, and failure to pay account balances as promised may be subject to external collection and additional collection fees, including attorney and other court fees. We may investigate your credit record to determine your ability to pay your debt.

Missed / Cancelled Appointments: Charges may be made for missed, confirmed appointments and appointments cancelled without 24 hours notice. Your cooperation in cancelling your scheduled appointment well in advance allows us the opportunity to offer your appointment to a person who needs medical care. **Failure to show for a scheduled confirmed appointment may result in a $75 no-show fee per scheduled provider.**

I acknowledge that:
~ I have read this form and understand its content
~ I am the patient or person duly authorized either by the patient or otherwise, to sign this agreement, consent to and accept its terms.
~ I am responsible for the payment and/or co-payment that is due at the time of service.

_____ _____
Signature of Patient or Responsible Party Name (Print)

_____ _____
Relationship to Patient Date

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