KEY THERAPEUTICS, LLC

Karen Andrews, P.T., MTC, CSCI

(240) 405-4424

www.KeyPt.US

FINANCIAL POLICY

Thank you for choosing Key Therapeutics and Karen Andrews P.T., MTC, CSCI as your physical therapy provider. We are committed to providing our patients with caring, competent service and treatment. We provide no guarantees of a certain result, as every patient's response to treatment is unique and difficult to predict with any degree of certainty.

The following is a statement of our financial policy, which we ask that you read and sign prior to your first visit. By signing below, you agree to the terms of this financial policy for all subsequent treatment by Key Therapeutics and Karen Andrews P.T., MTC. CSCI.

Forms of accepted payment:
Payment for service(s) is due at the time of each visit. We accept cash, personal checks, Venmo, Zelle and all major credit cards. Please be aware, we do not submit claims to your insurance company. We ask that you make payment for each treatment visit prior to leaving the office.

Out-of-Network Policy :
We will provide you with a copy of your bill that, at your discretion, you may submit to your health plan for reimbursement for the services your health plan covers. You are responsible to obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.

Health Insurance:
Key Therapeutics/Karen Andrews P.T. MTC, CSCI are out-of-network providers with all commercial insurance companies.

Personal Injury (PIP) is not accepted at this time
Workman's Compensation is not accepted at this time.

Payment Allocation:
We request that insurers/third party payers forward payments directly to the patient. However every insurer/third party payer has their own internal policies for processing and payment of claims. Some will issue a check to the patient; others will issue a check to the subscriber (in some cases, that person will be different from the patient); some will issue checks to the provider. If we receive a check from an insurer made payable to the patient, we will return the check to the insurance company and request direct payment to you.

In rare instances, a patient may receive a reimbursement check in an amount that exceeds the fee paid to the provider. If that occurs, it is a patient's responsibility, in accordance with their contract with their insurer/third party payer, to refund the excess reimbursement amount to their insurer/third party payer. By signing below, you are agreeing to this arrangement.

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Missed appointment/late cancellation fee:
It is our policy to charge a $230.00 fee for missed appointments or cancellations with less than 24 hours notice. Please note that if you leave a message on our voicemail to cancel an appointment, we will use the time of the message in order to calculate the 24-hour time period. The cancellation fee must be paid before the next visit is scheduled. If a patient misses or fails to cancel three (3) appointments, we reserve the right to discharge the patient from our practice.

Financial Authorization:
By signing below, I acknowledge and understand that I am financially responsible for all professional services provided by Key Therapeutics LLC and Karen Andrews P.T., MTC, CSCI. I understand and agree to make payment directly to Key Therapeutics/Karen Andrews P.T., MTC, CSCI. I understand that Key Therapeutics LLC and Karen Andrews P.T., MTC CSCI do not accept or participate with my health insurance company. I have had the opportunity to ask questions about the above terms of this financial policy, and by signing below, agree to the above financial obligations.

Appeals Policy:
You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.

If you are under the age of 18, your parent or guardian must sign this financial policy, and agree that he/she will be responsible for payment of services.

_____ _____
PATIENT NAME DATE

_____ _____
PATIENT SIGNATURE RELATIONSHIP (IF NOT PATIENT)