UNIVERSITY OF MONTANA
PHYSICAL THERAPY CLINIC
EXCELLENCE IN MOTION
32 CAMPUS DRIVE, SKAGGS 129 • MISSOULA MT 59812 • P 406-243-4006 • F 406-243-4303

Payment Policies: Initials and Signature Required

The University of Montana Physical Therapy Clinic strives to provide high quality, patient-centered physical therapy care while serving as a teaching facility for graduate students. Your care will be provided by a highly qualified physical therapist and graduate physical therapy interns. Please read the following information and initial/sign as requested.

CLINIC POLICIES: Initials required after each paragraph indicating you agree to follow these policies.

1. A **parking pass** will be provided for you. Please note that the **pass is applicable only during the time of your physical therapy** appointment and using the clinic's parking at other times risks ticketing or towing.
   Initials_____

2. We will bill insurance for you if we accept assignment. Ask if your insurance is accepted, and what is required for us to bill your insurance. **If your insurance requires preauthorization, it is your responsibility to inform us that it is required. We will submit forms needed. Initial_____**

3. **You will be responsible for the deductible and co-pays, and for knowing your insurance coverage caps**. Co-pays will be collected at time of service. If necessary, payment plans for charges not reimbursed by insurance can be arranged with our billing manager. **Initial_____**

4. **Please check the box which applies to your specific insurance or method of payment:**
   - ☐ MUS Student Insurance: CoPays are required
   - ☐ Out of State Private Insurance: What is it?_____ PreAuth Needed? N/A
   - ☐ Private Insurance (In State): What is it?_____ PreAuth Needed? N/A
   - ☐ Medicaid: 40 visits/year; $2-$4 copay is required. MD referral is required.
   - ☐ Medicare: Traditional (Medicare pays 80%)
   - ☐ Federal, such as TriCare, VA and others may have pre-authorization requirements
   - ☐ Payment at time of service: Cash, Credit Card, Check accepted. Discounts applied.
   - ☐ Secondary Insurance (Name) _____
   - ☐ Tertiary Insurance (Name) _____

5. If you are unable to keep your appointment please provide 24 hour advanced notice, otherwise a $25.00 cancellation fee may be administered (which is not covered by insurance). **Initial _____**

*I hereby authorize The University of Montana Physical Therapy Clinic to release all information regarding my physical therapy treatment to my health insurance, physician, attorney, or responsible insurance carrier.

*I authorize treatment and agree to be responsible for all payment not covered by my insurance, unless prior arrangements are made.

_____ _____

Signature Date

Guardian if applicable (Print name)_____