Sari Hands PLC
Financial and Cancellation Policies

Welcome to our office. Early communication with patients regarding financial policies helps us to provide you with the best service. As a courtesy, we will bill your health insurance for your therapy visits.

Patients with contracted managed care plans: Payments for co-pays, deductibles and/or non-covered portions are due at the time of your visit.

Patients with private insurance plans/non contracted insurance plans/out of state patients/uninsured patients: Payment is due in full at the time of service. We will provide you with a receipt to submit to your insurance plan for reimbursement.

Insurance Payments: If your insurance pays directly to you, we request payment in full at the time of service.

Address and Insurance Changes: Please keep us informed of any insurance, address, telephone number, employment or other personal information changes.

Collection procedures: If an account advances to collections, the patient is financially responsible for all costs incurred in collecting said account (i.e. attorney fees, court costs, filing fees, etc.) Any balance assigned to collections will be assessed a 30-40% fee to offset the recovery expense. Once an account is placed in collection status, all future services must be paid in full at the time of service.

Ultimately, you are the responsible party for payment. We consider any account over 60 days from the date of your first statement delinquent. ***Our office does not routinely extend payment plans.*** For your convenience, we accept cash, personal (in state) checks, Visa and MasterCard.

Cancellation Policy: Please notify our office at least 24 hours in advance if you need to cancel your appointment. ***A $75 fee may be assessed for appointments missed due to late cancellation or no-show.*** Payment for these charges is due before your next visit. Cancellations will be noted in your patient records. Three missed appointments without proper notice is cause for dismissal from our office.

I have read and understand this financial and cancellation policy statement and agree to abide by the terms of these policies. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment of a claim after our office has submitted it.

Signed: _____ Printed Name: _____

Date: _____ Witness: _____