Patient Responsibility & Payment and Refund Payment of copays and deductibles will be due at time of service. Collection is required by your insurance companies for these amounts. You are ultimately responsible if your insurance denies a claim for any reason. If you do not have insurance payment in full will be due at time of service. The amount of your bill is expected to be paid in full within 30 days of the date on the statement, unless payment arrangements have been made with the Billing and Accounts Manager, or Billing Coordinator. Anything over 30 days is considered past due. Refund/Return Policy on Services: All sales on services provided are final. This includes package deals for discounted services. All packaged/discounted treatment plans are final but there is no expiration on the purchased sessions. All packages are allowed for one time exchange of unused portions toward other purchased services at our clinic.

Payment Options - Credit Card on File
For your security and protection, Accelerate Therapy and Performance stores your encrypted and tokenized credit card data in an off-site, secure vault that exceeds all HIPAA and PCI security standards

I authorize Accelerate Therapy and Performance to automatically debit the card on file for any patient responsibility, including standard copays, remaining balance, payment plans and no-show fees.

I understand that I can update my card information on file at any time by contacting our office directly. In fact, it is my responsibility to notify Accelerate Therapy and Performance of any updates or changes to the credit card on file associated with this agreement as soon as possible.

Credit Card Information

Card Type: Visa Mastercard American Express Discover

Name on Card:_____

Credit Card Number: _____CVV:_____

Exp (MM/YY):_____ Billing Address:_____

Billing Zip Code:_____ Email:_____

Non-Payment
Failure to pay will result in your account being referred to a collection agency, which will affect your credit. NSF checks will result in a $25.00 returned check fee.

> I have received this financial policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be referred to a collection agency. If it becomes necessary to send my account to a collection service, You agree to reimburse the fees of any collection agency, which may be based on a percentage at a maximum of 30% of debt, and all costs, and expenses, including reasonable attorneys' fees, we incur on such collection efforts.

_____

Patient Signature Printed Name Date

_____

Parent/Guardian Signature Printed Name Date