

# Vail Sports Medicine Physical Therapy, P.C. Insurance Policies and Procedures

As a courtesy to our patients, we will bill your primary insurance as long as we receive the complete insurance information. Please bring your insurance card to your first appointment so that we may make a copy of it. If we do not receive this information at your first visit, we cannot be responsible for billing your insurance company. Submitting this information to us in a timely manner enables us to correctly bill your insurance company. Many insurance companies have a timely filing limit, usually 90-180 days. It is ultimately your responsibility to see that your bill is paid in a timely manner, and to follow up with your insurance company if this has not occurred. Payment plans made be made by calling our business offices at (970) 476-7510, regular monthly payments are expected. Co-payments may be made weekly or monthly, providing we have a credit card for you on file.

It is the patient's responsibility to know his/her insurance benefits pertaining to physical therapy treatment. We are not responsible for any denial of claims: including denials due to lack of pre-authorization, or because of delays in receiving your health insurance information, or due to any limitations on your coverage for physical therapy. If you have any questions regarding your insurance benefits, please call your insurance company's customer service phone # (this is generally located on the back of your insurance card).

Vail Sports Medicine Physical Therapy, P.C. is a preferred provider for many insurance groups, including:

- Sloans' Lake Managed Care
- Aetna
- Humana/Choice Care
- Blue Cross/Blue Shield (all states)
- Medicare
- United HealthCare
- Rocky Mountain Health Plans
- Great West
- GEHA

I have presented Vail Sports Medicine Physical Therapy, P.C. with my insurance card. I understand that any changes to my health insurance coverage must be reported to Vail Sports Medicine Physical Therapy, P.C. in a timely manner (i.e. I changed insurance companies, my coverage for physical therapy ran out, etc.)

Date: \_\_\_\_\_

Patient signature: \_\_\_\_\_

Parent/Guardian signature: \_\_\_\_\_

*(if necessary)*

Date received by VSMPT staff: \_\_\_\_\_