COASTAL REHAB
PHYSICAL THERAPY + SPORTS + SPINE

Payment Policy

If you have any questions concerning your treatment or bill for services, please contact us immediately.
PHONE: 252.338.2114

You are ultimately responsible for your balance regardless of insurance coverage, liability of another party, or representative by attorney

We will file personal health insurance for you. You will be responsible for any deductible and/or co-payment. We require that you make a payment each week towards your balance while receiving treatment. You are responsible for any treatment cost not covered or not reimbursed in a timely manner by insurance or third party payer. After discharge, the balance is due in full within (90) days.

If you are not covered by personal health insurance, you will be required to make payments towards your charges each week while receiving treatment. If you are not able to make weekly payments, you must make acceptable payment arrangements with the Office Manager before beginning treatment.

If you are involved in any liability or legal proceedings, for example an automobile accident where someone else is at fault, and you are working with auto insurance companies or an attorney, please advise us. However, we will not hold your account until settlement; your balance will be due in full within (90) days of discharge. You are responsible for your balance and will be required to follow all payment policies on this page even if an attorney represents you.

After discharge from therapy, the balance of your account is due and payable in full within (90) days of discharge. If you need to make other arrangements, please contact our Office Manager.

If your account becomes delinquent it will be forwarded to a collection agency, and you will be responsible to pay all reasonable collection and handling charges on the outstanding balance. Your account may be subject to finance charges of 1.5% per month on all unpaid balances.

In the event that your account must be referred to an Attorney for Collection proceedings, we reserve the right to request recovery of reasonable counsel fees incurred for collection in addition to your outstanding balance.

I AGREE TO MAKE PAYMENTS AS INDICATED ABOVE WHILE BEING TREATED AT COASTAL REHABILITATION, INC. I UNDERSTAND THAT AFTER DISCHARGE, THE BALANCE IS DUE AND PAYABLE IN FULL WITHIN (90) DAYS OF THE LAST TREATMENT REGARDLESS OF INSURANCE COVERAGE, SOMEONE ELSE BEING AT FAULT, OR HAVING AN ATTORNEY.

I HAVE READ, UNDERSTAND, AND AGREE TO COMPLY WITH THE ABOVE POLICY REGARDING PAYMENT OF MY ACCOUNT AT COASTAL REHABILITATION, INC.

Signature: _____ **Date:** _____

E | info@coastalrehabnc.com **P** | 252.338.2114 **F** | 252.338.2115