action sports medicine
specialized training • injury treatment + prevention
p: (415) 307-0595
f: 866-826-1821

General Policy & Procedures

Assignment of Benefits/Financial Responsibility:

Once we have identified that we are a provider under your insurance carrier we will bill your insurance carrier directly in order to receive payment for our services on your behalf to Action Sports Medicine. **Clients/Patients are responsible for necessary services not covered by their insurance carrier**. **Co-Payments are due on the date of service.**
Questions regarding bills sent to your home can be addressed to: **Keller Billing (408) 323-2312**
The client/patient is ultimately responsible for knowing the details of their coverage (i.e. deductibles, co-payments, limits on number of visits, percent of coverage), which may influence the extent of their financial responsibility.

If we are NOT a provider under your insurance carrier then the services furnished by Action Sports Medicine are charged directly to the client/patient, and he/she (or the financially responsible party) is responsible for payment. You will be informed of these circumstances before the start of your 1st session. See "Self-Pay" section below.
We will do everything possible to assist you in obtaining reimbursement from your insurance company. An itemized bill will be given to you after each visit with codes and documentation regarding your session(s).

Self-Pay: (specialized training & physical therapy clients):

Action Sports Medicine offers a number of payment options, including Master Card, AmEx and VISA. Payments are due on the date of service. Payment of multiple sessions is due on the date of the 1st session. Detail of services and their corresponding costs will be explained before each session.

Cancellations/No-Shows:

As a courtesy to our staff and clients we would appreciate all cancellations be made 24 hours in advance. There is a session fee for No-Shows or cancellations made less than 24 hours.

Consent for Testing & Treatment:

By signing below you are authorizing the therapists, rehabilitation workers and employees of Action Sports Medicine (and persons authorized by such other institutions as may be requested by Action Sports Medicine) to carry out examinations, testing procedures and treatment deemed necessary and advisable for your diagnosis, treatment and continuing care.

Notice of Privacy Practice:

By signing below you acknowledge that you have received and read the Notice of Privacy Practice (please download from website or one may be given to you in the clinic). Disclosure of your protected health information will solely be utilized for the purpose of physical therapy evaluation and/or providing treatment, coordination with an appropriate vendor for durable medical equipment needed for you, obtaining payment from insurance carrier(s). You have the right to request a restriction as to how your health information is used or disclosed in respect to your care with our practice.

By signing below you acknowledge having read and understand the above policies/procedures.

Print Full Name | Signature of Patient/Client | Date

Legal Guardian (if client under 18) | Signature of Legal Guardian | Date