ASHWOOD PHYSICAL THERAPY, INC.
3737 Telegraph Road, Suite A, Ventura, CA 93003
Phone: (805) 642-4678

OFFICE FINANCIAL POLICY

Patient Responsibility: You are responsible for all costs related to your care, including copayments, deductibles, coinsurance, and any balances not covered by insurance. We accept all major credit and debit cards. A credit card may be kept on file to process outstanding balances. **By maintaining a credit card on file, you authorize Ashwood Physical Therapy to charge applicable copayments, balances, and missed appointment fees.**

Cancellation & No-Show Policy: Please provide **24 hours notice** for cancellations or rescheduling. A **$75 fee** will be charged for: Late cancellations (less than 24 hours notice) or Missed appointments (no-shows) unless rescheduled same week. **This policy applies to all patients regardless of insurance type.**

Insurance Billing: We are in network with most **PPO** plans and a **Medicare-approved** provider. Medicare determines the allowable amount for your care.

- **Medicare PART B Threshold:** Medicare tracks therapy services toward an annual threshold. For **2026, the combined threshold for physical therapy and speech therapy is $2,480 per year**. Reaching this amount does **not automatically stop therapy**, but additional documentation is required to support continued care.

- **Medicare Coverage:** Medicare covers physical therapy services based on **medical necessity**. If services are not considered medically necessary, Medicare may deny payment. In that case, **you are responsible for any non-covered charges**. We will notify you in advance if your treatment may not be covered and provide appropriate documentation (ABN) when required.

- You are then responsible for your **20% coinsurance**, unless a secondary insurance covers this portion. Payment is due at the time of service. Our office will submit claims to your insurance, any balance not paid by your insurance is your responsibility.

(HMO or Medi-Cal): We do not currently accept HMO or Medi-Cal plans. Patients with these plans are welcome to receive care on a self-pay basis. Please inquire about our cash-pay options.

Acknowledgment: I have read and understand the Office Financial Policy and agree to the terms outlined above.

Patient Name: _____ Signature: _____

Date: _____