The Hand and Upper Body Rehabilitation Center
Financial Policy and Privacy Practice Acknowledgement

Thank you for choosing us as your health care provider. We are committed to your successful treatment. Please understand that payment of your bill is considered part of your treatment. The following is our Financial Policy that we require you to read and sign prior to any treatment. All patients must complete this form before seeing the therapist.

PAYMENT IS DUE AT TIME OF SERVICE UNLESS ARRANGEMENTS HAVE BEEN MADE TO BILL YOUR INSURANCE CARRIER. WE ACCEPT CASH, CHECKS OR VISA/MASTERCARD.

REGARDING YOUR INSURANCE:

Please remember that insurance is considered a method of reimbursing the patient for fees paid directly to the provider and **is not a substitute for payment.** While the filing of insurance claims is a courtesy that we extend to our patients, **all charges are your responsibility.** It is the patient's ultimate responsibility to pay any deductible amount, co-insurance or balance not paid for by your insurance company. If we are filing your insurance claim we will allow 45 days for processing and payment from your insurance carrier. If payment is not received within 45 days we will notify you to pay your account in full and seek reimbursement from your insurance carrier. In the event your account becomes delinquent it will be assigned to a collection agency. The patient agrees to pay all costs of collections including any court costs, sheriff or attorneys fees, and collection fees. **ALL COPAYS AND DEDUCTIBLES ARE DUE AT TIME OF TREATMENT. IN THE EVENT THAT YOUR INSURANCE IS NOT A PLAN WE PARTICIPATE WITH REFER TO THE ABOVE PARAGRAPH.**

REGARDING WORKERS COMPENSATION:

If you are a patient with a valid Workers Compensation claim, we will bill your insurance carrier for reimbursement on all treatment rendered. Patients whose claims are denied by Workers Compensation must pay their balance due within 45 days or provide our office with private insurance coverage to bill**. Please bear in mind that simply filing a claim with a Workers Compensation carrier does not guarantee acceptance or payment of your medical bills**. We must emphasize that it is YOUR responsibility to ensure that your employer has filed your claim and all information required by the carrier has been received.

REGARDING MEDICARE:

The Hand and Upper Body Rehabilitation Center will bill Medicare and your supplemental insurance company as a courtesy to you. Medicare will pay 80% directly to us, and the other 20% must be collected from the patient or supplemental insurer. Medicare will not pay more than $1860.00 per calendar year for therapy received outside of a hospital setting. This amount does not include splints or Durable Medical Equipment. If you should exceed this cap limit we will either apply for a "Therapy Cap Exception" or recommend a hospital therapy department where you may continue treatment.

Many Insurance Plans and Medicare Will Not Cover Equipment or Supplies. You Will Be Financially Responsible for These Items If Not Covered By Your Insurance.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing you with the best possible care and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of rates.

CONSENT FOR MEDICAL TREATMENT:

The undersigned hereby consents to any therapy, treatment, or services rendered under the general and special instructions of the therapist assigned to care for me. I also acknowledge that there is no guarantee of treatment outcomes or results.

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION:

The Hand and Upper Body Rehabilitation Center is hereby authorized to disclose all or any part of the medical record of the patient named on this registration to such insurance companies or agencies as may be concerned with the payment of professional and/or facility costs of said patient.

NOTICE OF PRIVACY PRACTICES:

Our Notice of Privacy Practices is posted in the waiting room of our facility. We will supply you with a copy upon request.

I certify that I have read and understand fully the providers **Financial Policy** and have read the **Notice of Privacy Practices** and may request a copy for my records. I agree to make payment in full and/or satisfactory arrangements when asked to do so as specified above.

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Signature of Patient or Responsible Party Date