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Patient's Name

PHYSICAL THERAPY & SPORTS REHAB OF HASTINGS (PTSR)
FINANCIAL POLICY AND AGREEMENT

Thank you for choosing Physical Therapy & Sports Rehab of Hastings for your rehabilitation needs. We appreciate that you have entrusted us with your healthcare and are committed to providing you with the best patient care possible. The following explains our **Financial Policy and Agreement** which must be read and signed prior to any current or future medical evaluation or treatment in our office.

Healthcare benefits and coverage options have become increasingly complex which is why we have developed these policies to help you better understand your responsibilities and to eliminate any unnecessary confusion.

If you have any questions, please do not hesitate to ask our front office staff.

COVERAGE AND RESPONSIBILITY

NEXT TO YOUR APPROPRIATE COVERAGE, PLEASE INITIAL THAT YOU HAVE READ AND UNDERSTAND YOUR RESPONSIBILITY:

HEALTH INSURANCE

_____ **(Initial)**

I am covered by a **HEALTH INSURANCE** plan(s) and I hereby assign all payments on claims to go directly to PTSR. I agree to pay the amount my insurance plan indicates that I am responsible for at the time of service (i.e. co-pays, etc.) I will also handle any discrepancies directly with my insurance company. I understand that not all health coverage plans cover supplies; therefore, I will pay for any supplies at the time the item is dispensed.

I also understand that PTSR will make every attempt to verify current insurance coverage for me; however, I know that verification of benefits is **NOT** a guarantee of payment.

- ***Since coverage is unique to each policy, I am ultimately responsible to verify my therapy benefits regarding specific provisions (i.e. need for a physician's referral, pre-authorization, number of allowed visits, co-payment amounts, etc.).***

Unless prior financial arrangements have been made, outstanding balances are payable, in full, no later than 30 days (after notification date).

MEDICARE

_____ **(Initial)**

I am a **MEDICARE** recipient, and understand that PTSR will file my claim to Medicare. I also understand that payment for services will go directly to PTSR. **ONCE MY DEDUCTIBLE HAS BEEN MET**, Medicare will cover my claim at 80%. I will then be responsible for the remaining 20% unless I have furnished a secondary insurance. I understand that I may be responsible for any balance due depending upon my secondary insurance coverage. Keep in mind that most secondary insurance plans do not cover Medicare's annual deductible. I understand that Medicare does not cover all supplies. If I wish to purchase a supply, I am expected to pay at the time it is dispensed. Unless prior financial arrangements have been made, outstanding balances are payable, in full, no later than 30 days (after notification date).

MEDICARE ADVANTAGE PLAN

_____**(Initial)**

I am a **MEDICARE ADVANTAGE** recipient and understand that PTSR will file my claim and that payment for services will go directly to PTSR. I understand that with this type of coverage, I will be responsible for a co-pay. I also understand that my insurance does not cover exercise supplies. If I wish to purchase any supplies, I am expected to pay at the time the item is dispensed. Unless prior financial arrangements have been made, outstanding balances are payable, in full, no later than 30 days (after notification date).

MEDICAID

_____ **(Initial)**

I am covered by **MEDICAID MANAGED CARE** and will produce my current Medicaid card each month I am receiving therapy for the purpose of verification of coverage by PTSR. I understand that payment for services will go directly to PTSR. I understand that Medicaid does not cover all types of supplies; therefore, I will be responsible for payment at the time of service.

WORKERS COMPENSATION

_____ **(Initial)** I have a work-related injury and have notified my employer. I understand that all charges remain my responsibility until a Workers' Compensation claim is **validated** by my employer and/or their agents. Upon authorization, PTSR will bill my employer for the services rendered and payment will be made directly to PTSR. In the event of a dispute or denial with my employer regarding the work injury, I accept full responsibility for payment on my account at the time of service. I understand that I would also have the option to send claims through my health insurance plan upon any denial or dispute.

NO INSURANCE

_____ **(Initial)** I have no insurance coverage and I will pay at the time services are rendered.

LIABILITY INSURANCE (Med Pay)

_____ **(Initial)** I have been involved in an accident and have verified medical payment coverage through my auto or health insurance. I understand that I am responsible to provide the name and address of the auto insurance carrier along with a claim number to PTSR. If I am unable to provide verifiable billing information, I will continue on a cash basis until this information is obtained. I understand that payment for services will go directly to PTSR. I am also aware that I am responsible for payment on my account, at the time services are rendered, once my med pay has been exhausted. At that time, I understand I then have the option to submit claims to my health insurance plan. (Lawsuit/Settlement obligation section may also apply, see below)

LAWSUIT/SETTLEMENT

_____ **(Initial)** Although, I am involved in litigation, I am responsible for payment on my account at the time services are rendered. I understand that PTSR will not wait for payment from any settlement I may or may not receive in the future. I also understand that PTSR will not agree to bill an attorney for services rendered. I also have the option to submit claims to my health insurance plan once they have been notified of the situation.

DECLARATION

The undersigned hereby acknowledges that PTSR may release information from my medical records during the period of such care to the health insurance company, Worker's Compensation insurance, third party payors, other health plans and/or other health practitioners for the purpose of processing claims and to obtain payment on the account for services rendered.

The undersigned acknowledges responsibility for services not covered by insurance including care that insurance deemed as "*not medically necessary*".

The undersigned hereby acknowledges that Physical Therapy & Sports Rehab of Hastings has made available to me their *"Notice of Privacy Practices"* for protected health information.

The undersigned hereby acknowledges that Physical Therapy & Sports Rehab of Hastings will not agree to bill an attorney for services rendered on behalf of the patient.

The undersigned hereby acknowledges that any returned checks will be subject to a **$25.00** fee.

The undersigned hereby acknowledges that in the event the account is turned over to the collection agency, the collection fees and/or legal fees, including attorney fees, shall be my responsibility.

This agreement is binding upon the patient, his/her successors and assignees. My signature below indicates that I am accepting financial responsibility for all services rendered and certify accuracy of information as noted above. If signed by an individual other than the patient, that individual agrees that he/she will assume full financial responsibility for the patient and understands the Declaration. A copy of this financial agreement may be used in lieu of the original.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ THIS AGREEMENT AND UNDERSTAND IT FULLY.
PTSR WILL PROVIDE ME WITH A COPY OF THIS DOCUMENT, UPON MY REQUEST.

_____ _____ _____

Signature (*Must be 18 years old to sign*) Relationship to Patient Date

Witness/Date: _____