FINANCIAL POLICY

PAYMENT IS DUE WHEN SERVICES ARE RENDERED. Please read our financial policy carefully. If you have any questions about this policy, our staff will be glad to assist you.

PAYMENT PROCEDURE: (Please check the manner in which you will be paying)

( ) GROUP HEALTH INSURANCE:
We will file your claims to your insurance company and verify your benefits. We will inform you of any deductible, coinsurance or copayment amounts as quoted by your insurance. We require that you pay any deductible, copayment or coinsurance at the time of treatment. Benefits are subject to final approval by your insurance company; therefore, the amount is subject to change. **We file primary insurance as a courtesy; however if you have secondary coverage and would like our office to file there will be a $10.00 fee (this does not apply to Medicare secondary coverage). INITIAL____**

( ) SELF PAY: Payment is due when services are rendered. **INITIAL_____**

( ) **AUTO ACCIDENT/PERSONAL INJURY:**
This office **DOES NOT** accept liability insurance as a form of payment. We do not get involved in the legal procedures; therefore payment is due at the time services are rendered. We are, however, eager to assist all patients in need of care. We will be glad to verify auto accident/personal injury benefits with your personal health insurance**. INITIAL_____**

( ) **WORKERS COMPENSATION:**
We will accept worker's compensation if your insurance carrier or employer notifies our office prior to your visit with verification and authorization for services. **WE WILL NEED A COPY OF YOUR GROUP INSURANCE CARD** to keep in your file should your worker's comp claims be denied, at which time, you would be responsible for the bill. **INITIAL____**

**** Any balance that remains unpaid 20 days after services are rendered is the responsibility of the patient/guardian and will be subject to a finance charge. *** Delinquent accounts will be forwarded to a collection agency if payment is not received.* ***INITIAL_____***

**** There will be a $25 fee for appointments cancelled or broken without 24 hour advanced notice.** INITIAL____**

Your signature is consent for Dosher Physical Therapy Associates to use automated or predictive dialers to contact you on all numbers provided, including cell phones, concerning any unpaid or remaining balance on your account. This will also include any outside collection agency if your account is assigned to collections for delinquent or past due accounts. **I understand that I am financially responsible for services not covered or deemed not medically necessary by my insurance company. I further understand that Dosher Physical Therapy Associates may not be aware of non-covered services at the time of treatment. I have read and understand my obligation.**

_____ _____

Patient Signature or Guardian if a minor **Date**

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE **DOSHER PHYSICAL THERAPY ASSOCIATES** TO ADMINISTER TREATMENT AS NECESSARY. I ALSO UNDERSTAND THAT NO GUARANTEE HAS BEEN MADE AS TO THE RESULTS THAT MAY BE OBTAINED.
I authorize the release of information in the course of treatment including, but not limited to medical records, oral communications to my insurance company, employer (if applicable) physician and/or third party. **INITIAL____**

BENEFIT ASSIGNMENT: I hereby authorize payment be made directly to Dosher Physical Therapy Associates. If my insurance company should require that payment be made to me, I will in turn issue payment to Dosher Physical Therapy Associates for any charges that I have not previously paid and/or charges that are not covered by my insurance company. **INITIAL____**

PATIENT ACKNOWLEDGEMENT OF RECEIPT OR REQUEST OF NOTICE OF PRIVACY PRACTICES

A copy of Dosher Physical Therapy Associates (herein after "DPTA") Notice of Information Practices is available upon request. I understand DPTA may use or disclose my personal health information (herein after "PHI") for purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand I have the right to restrict how my PHI is used and disclosed if I notify the practice. I also understand that DPTA will consider requests for restriction on a case by case basis, but does not have to agree to requests or restrictions.
I hereby consent to the use and disclosure of my PHI for purposes as noted in DPTA Notice of Information Practices. I understand I retain the right to revoke this consent by notifying the practice in writing at any time. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

_____ _____

Patient Signature or Guardian if a minor **Date**

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because: It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____Other (please describe)
_____ Signature of Privacy Officer