ORTHOPEDIC & SPINE THERAPY

FINANCIAL/CONSENT TO TREAT POLICY

Thank you for choosing us as your health-care provider. We are committed to your treatment being successful. The following is a statement of our Financial/Consent to Treat Policy, which we require you to read and sign prior to treatment. If at any time you have questions regarding any treatment, fees, or services please discuss them with us.

REGARDING INSURANCE:

As a courtesy to you, we will bill your insurance carrier. Please be aware some and perhaps all services may be "non-covered" and are not considered reasonable and necessary under some medical insurance policies. In addition, we charge what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates. **Co-pays are due at the time of your appointment.**

MEDICARE:

We do accept assignment for Medicare. There are certain guidelines that we, as an independent physical therapy practice, are required to follow. You agree to authorize payment of Medicare benefits to Orthopedic & Spine Therapy for any services furnished. In addition, you agree to authorize payment of Medicare benefits to Orthopedic & Spine Therapy or any services furnished.

WORKERS' COMPENSATION:

In the case of a work-related claim, we will bill the appropriate workers' compensation carrier. If the claim is unsettled or unpaid within 60 days, you will receive a statement from our office. If the claim is denied, you will then receive notice, as well as from the workers' compensation carrier. Upon notification, we will bill you or your personal health insurance carrier. Documentation of any missed appointments is forwarded to your Case Manager and Primary Physician, which could jeopardize your claim. Additionally, I agree to authorize OST to forward my medical records with any and all claims to work comp carriers and/or employers to assist in claims processing.

INJURIES/ACCIDENTS INVOLVING LEGAL LITIGATIONS:

We will not bill third party insurance if your injury or accident involves legal litigation; however, we will bill you or your health insurance. We will require you to make payments on the charges even if the third party will cover them. Documentation of any missed appointments is forwarded to your Case Manager and Primary Physician, which could jeopardize your claim.

SUPPLY ITEMS/DURABLE MEDICAL EQUIPMENT:

Occasionally, your therapist will recommend a particular supply item, foot orthotics, braces, Saunders Cervical Traction Unit, etc. that may be beneficial to your treatment but will be a "non-covered" benefit under your insurance policy. Please note: there are personal use items; therefore they are not returnable or refundable.

CANCELLATIONS/NO-SHOWS:

We require a 24-hour notice in the event of a cancellation. There is a $50 charge per 40-minute appointment for cancellation without proper notice or failure to show for your scheduled appointment. This charge will not be covered by insurance and the patient/responsible party will be financially responsible for the balance. Additionally, if you fail to show or cancel more than two times during the course of treatment OST reserves the right to discharge you from care.

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FINANCIAL RESPONSIBILITY/DELINQUENT ACCOUNTS:
Patient balances over 60 days will accrue late charges at the rate of 1% a month.

NON-SUFFICIENT FUNDS (NSF) CHECKS:
There is a $50 charge for returned checks with insufficient funds.

COLLECTION AGENCY PLACEMENT POLICY:
You are financially responsible for the timely payment of your outstanding bill per our payment policies. You will be responsible for any and all collection agency fees up to 30% of the amount placed with the collection agency. In the event we seek legal action for the collection of your account, you will also be responsible for actual fees associated with the court costs, garnishments, and/or attorney fees.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION/ASSIGNMENT OF BENEFITS:
You hereby authorize Orthopedic & Spine Therapy to provide treatment, release information pertaining to your treatment for insurance purposes, and/or to receive direct insurance payments otherwise payable to you for services rendered.

CONSENT TO TREAT:
There are potential risks and benefits of physical therapy treatment. Potential benefits include an improvement in your symptoms and/or an increase in your ability to perform daily activities. You may experience increased strength, awareness, flexibility, and endurance in your movements. You will have a greater knowledge of managing your condition and the resources available to you. Potential risks may be due to the many movements and positions that are performed. It is not uncommon to experience temporary discomfort after treatment. Any concerns should be addressed with your therapist. Therapy will be most effective when you are compliant with your treatment plan as outlined by your physical therapist.

If you have questions or problems, please let us know and we will be happy to assist you in every way possible.

I have read the Financial/Consent to Teat Policy. I understand and agree to this policy.

_____ _____

(Patient or Responsible Party Signature) (Date)