Payment Policy

Thank you for choosing us as your provider for physical therapy services. We are committed to providing you with high a quality and affordable rehabilitation process. Because our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy document. Please read it, ask any questions you may have, and sign in the space provided. A copy will be provided to you upon your request.

1. Insurance. Knowing your insurance benefits is your responsibility. Please contact your insurance company with specific questions you may have regarding your coverage. As a courtesy to our patients, the Front Office staff will verify benefits and attempt to obtain precertification and authorization if necessary. However, all patients are responsible for monitoring the number of physical therapy sessions as they relate to plan benefit limitations and/or authorization limits. *Hands on Health will attempt to provide you with updates at your request but will not be responsible for monitoring session/visit counts.* Exceptions to this policy are only when patient financial responsibility is limited by statutory regulation such as Worker's Compensation claims, Medicare and Motor Vehicle fee schedules. All patients must request that payment of medical benefits be made and assigned to Hands on Health, PA.

2. Copayments. All copayments must be paid at the time of service. Copayments are part of the contract with your insurance company. Failure to collect copayments can be considered fraud. Please help us uphold the law by paying your copayments as indicated.

3. Non-covered services. Please be aware that some, and perhaps all, of the services that you receive may be non-covered or not considered "reasonable" or "medically necessary" by your insurer. In the event of non-payment for any date of service by your insurer, you are expected to pay the balance of the account within 14 days of the billing statement mailed to you.

4. Proof of Insurance. All patients must complete our Patient Intake Form before seeing the Physical Therapist. We must obtain a copy of a current valid insurance card to provide proof of insurance. If you fail to provide the correct insurance information in a timely manner, you may be responsible for the balance of your account.

5. Claim submission. *Our Accounts Receivable Department will submit your claims and assist you in any reasonable way to get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that your account is your responsibility whether or not your insurance company pays your claim. If they have not paid within 60 days, the balance will be billed to you. Your insurance benefit is a contract between you and your insurance carrier; we are not a party to that contract.*

6. Coverage changes. If your insurance coverage changes at any time in the rehabilitation process, you must provide the new information prior to the next treatment session to which it applies. You must notify us so that we can make the appropriate changes to help you receive your maximum benefits.

7. Nonpayment. If the patient balance of your account is over 30 days past due, you will receive a letter stating that you have 14 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid past 45 days, we may charge a service fee of $20.00 and refer your account to our collection agency. Accounts referred for collections may be reported to the four major National Credit Agencies and if not resolved, litigated in a court of law.

8. Additional Costs of Collection. Invoices will be deemed to be accepted by you unless Sports Physical Therapy is notified in writing within 14 days of the invoice if you dispute it. In the event of non-payment, Hands on Health may, in addition to the invoice charges and service fee, charge debt collection and/or legal fees incurred by Hands on Health in regard to the recovery of outstanding amounts. Where any part of your therapy account has fallen into arrears, then the totality of that account shall become immediately due and payable.

I have read and understand the payment policy and agree to abide by its guidelines.

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Print Patient Name **Date**

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Signature of patient or responsible party

Office Policy

I consent for Hands on Health, PA (HOH) to provide the physical therapy services and treatment considered necessary and proper in diagnosing and/or treating my condition.

I acknowledge having been notified of HOH's Notice of Privacy Practices. I understand that should I have any questions regarding these practices, I may contact HOH's Compliance Officer.

I consent to the use or disclosure of my protected health information by HOH for the purpose of diagnosing and/or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of HOH. I understand that diagnosis or treatment of me by HOH may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have a right to obtain a full account of how my protected health information is used during my treatment. I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. HOH is not required to agree to the restrictions that I may request. However, if HOH agrees to a restriction that I request, the restriction is binding on my treating PT and HOH.

HOH reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice by contacting the company's Compliance Officer by calling the office.

I have been informed of the Patient Bill of Rights.
I have been informed of the Notice of Privacy Practices.

Additional Fees
A $30.00 fee, or the actual bank charge if higher, will be assessed for any returned checks.
It is the responsibility of the patient to notify our office of any insurance and/or demographic changes. Denials resulting from the lack of information will become the patient's responsibility and be billed accordingly.

Additionally, it is the patient's responsibility to keep track of authorized visits to this office.

I have read and understand the office policy and agree to abide by its guidelines.

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Print Patient Name **Date**

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Signature of patient or responsible party