GloverTherapy.com

GLOVER PHYSICAL THERAPY and Pain Rehabilitation

Personal Treatment Specializing in Chronic Pain and Orthopedic Services.

BILLING PRACTICES AND OFFICE PROCEDURES

Please read and acknowledge by signing on page 2

Patient Name: _____ D.O.B: _____

CONSENT FOR HEALTH CARE SERVICES: I authorize consent for medical treatment at Glover Physical Therapy, PLLC.

AUTHORIZATION FOR RELEASE OR INFORMATION: Glover Physical Therapy, PLLC may release information from my medical records to any health care provider involved in my care and treatment. Glover Physical Therapy, PLLC may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, Glover Physical Therapy, PLLC is no longer responsible for the confidentiality of any information known or possessed by the payer

FINANCIAL AGREEMENT: I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Glover Physical Therapy, PLLC which are not paid by my health insurance or other payer. Accordingly, if there is no payment or response from the insurance company after 90 days, the balance will be transferred to patient responsibility and I will receive a statement from the billing department reflecting this. All charges are due and payable within 25 days of the bill date. If Payment is not made within 90 days from the date of the bill, I understand that my account will be turned over to Security Credit Systems which will ultimately result in an adverse credit rating. Furthermore I agree to pay all reasonable collection fees and legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Glover Physical Therapy, PLLC. Additionally, I understand that I am responsible for a $20.00 returned check fee in addition to any other associated bank charges if any payment made by me is returned for insufficient funds.

BILLING POLICY: As a courtesy, Glover Physical Therapy and Pain Rehabilitation agrees to bill my Insurance Company on my behalf. Glover Physical Therapy, PLLC will assist in obtaining information regarding co-pays/coverage limits/authorizations/referrals, etc. However I fully understand it is ultimately my responsibility to know my insurance plan. I am aware that I am solely responsible for providing adequate up to date billing/insurance information to Glover Physical Therapy, PLLC. Furthermore, I understand that I am financially responsible for all physical therapy charges incurred. Should my insurance carrier ever deny payment for treatment received, or retract payment made on services rendered, I personally will reimburse Glover Physical Therapy, PLLC for such services. Glover Physical Therapy and Pain Rehabilitation will do its best to accommodate me, the patient by entering into a re-payment agreement if necessary.

Continued on next page

WORKER'S COMPENSATION & NO FAULT (MOTOR VEHICLE ACCIDENTS):
If Worker's Compensation or No Fault is my **primary insurance**, I am responsible for providing Glover Physical Therapy, PLLC with accurate information regarding the date of injury, WCB and Carrier Case numbers (for Workers Compensation), Claim and Policy numbers (for No-Fault), as well as my insurance carrier's name and the appropriate billing address. I must also provide Glover Physical Therapy, PLLC with my personal health insurance information. Should my case ever deny additional treatment or payment, all outstanding balances and future services will be my responsibility unless covered by my secondary (personal) insurance. In order for Glover Physical Therapy, PLLC office to bill my private health insurance, all information must be provided at my initial appointment to ensure timely filing of claims.

OTHER INSURANCE: If Glover Physical Therapy, PLLC does not participate with my insurance or if I am uninsured and choose to pay the private pay fee, I am responsible for payment in full at the time of my visit. Glover Physical Therapy PLLC.'s private pay fee is $75.00 per visit.

REFERRALS AND AUTHORIZATIONS: I accept the responsibility to obtain all referrals or pre-authorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for coverage of Glover Physical therapy, PLLC charges.

ASSIGNMENT FOR DIRECT PAYMENT: I authorize direct payment of any insurance (including auto insurance, workers compensation and private health-care insurance) benefits for health care services or goods be made directly to Glover Physical Therapy, PLLC.

CO-PAYS, DEDUCTIBLES CO-INSURANCE: I am always responsible for applicable co-payments, co-insurance and deductibles as determined by my insurance company. All Co-pay's are expected at the time of service unless the billing department has made prior arrangements**.** Glover Physical Therapy, PLLC requires a per visit down-payment charge of $45.00 (to be paid at time of visit) from all patients whose insurance requires a deductible, until the deductible is met. Patients with a 10% co-insurance are asked for a per visit down-payment of $4.00, and for those with a 20% co-insurance we will require an $8.00 down-payment per visit. This is to ensure payment of patient accounts, and to ease the burden of patient responsibility.

LATE SHOW POLICY- Our providers know your time is important and we hope you understand the value of our time as well. We want to be able to provide every patient with all the attention they require. If you arrive more than 15 minutes late for your appointment, it may be necessary to reschedule for a later time or day, unless prior arrangements have been made. *It is at the discretion of the provider to see the patient or to ask the patient to reschedule. If it is determined that the provider will see the patient, the patient arriving late maybe required to wait until an appropriate opening is available.*

CANCELLATION / NO-SHOW POLICY: Glover Physical Therapy, PLLC kindly requests 24 hours notice for cancelling an appointment. We do understand that sometimes circumstances arise that make giving this much notice impossible, we ask in those cases that you call us as soon as possible to avoid a No-Show fee. Excessive late cancellations (more than 5 times) will be subject to a $20.00 fee. Glover Physical Therapy, PLLC will charge a $20.00 fee for ***all*** appointments missed *without* notification (**No-Show**). Please understand that you will be responsible for this charge and that your insurance company will not be billed for that day. Chronic no-show/same day cancellations may result in discharge from the practice for non-compliance with the Physical Therapist's plan of care.

I, _____ agree that I have received a copy of each of Glover Physical Therapy's billing and appointment policies on _____/_____/_____.
I acknowledge that: I have read this form and understand its contents. I am the patient, or person authorized by the patient, to sign, consent to, and accept its terms. I am ultimately responsible for payment of services rendered by Glover Physical Therapy PLLC.

_____ _____

Patient Signature **Signature of Patient Representative & Relationship**

_____

Reason for Patient Not Signing