STILLINGS-SMITH PHYSICAL THERAPY

FINANCIAL POLICIES

Thank you for choosing Stillings-Smith Physical Therapy for your rehabilitation needs. We appreciate that you have entrusted us with your health care and are committed to providing you with the best patient care possible. Please carefully read through the following financial information.

Because healthcare benefits and coverage options have become increasingly complex, we have developed these policies to help you better understand your responsibilities as a patient and eliminate any unnecessary confusion. We will do our best to assist you with understanding your proposed treatment and in answering questions related to submitting your insurance claim for reimbursement. Adhering to these policies will enable us to focus increased attention on providing quality rehabilitative services to our patients and run our clinic more efficiently.

If you have any questions in regard to the following information please do not hesitate to ask any of our staff members.

UPDATES: It is important that we have your correct information on file. Please advise us anytime there is any change to your address, telephone or other contact information. If you are issued a new insurance card please allow us to take a copy of it for your file. If your insurance changes or discontinues mid-treatment, please notify us immediately so there is no delay in billing.

PATIENT PRIVACY: Stillings-Smith Physical Therapy is committed to protecting the privacy and security of our patients and all Protected Health Information (PHI). During the course of treatment it may be required to share information with other medical providers. We follow all Federal and State laws and regulations regarding PHI and information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual as provided by law. If you have any questions please contact one of our staff members. If requested, we can provide you with a copy of our "Statement of Privacy Notice".

INSURANCE COVERAGE: As a service to our patients, Stillings-Smith Physical Therapy is more than happy to directly bill your insurance for services rendered, but it is our policy that the patient is ultimately responsible for payment of the services received from SSPT. Furthermore, the patient is responsible for understanding their insurance coverage in relation to covered services and is responsible for providing SSPT with the most current insurance information.

We make every attempt to verify your current insurance coverage. Verification of benefits is NOT a guarantee of payment. Information we collect includes: effective dates, deductibles, co-payments and co-insurance amounts. We will try and review this information with you at your next visit. If you are unfamiliar with any of the terms used to explain your insurance benefits, please don't hesitate to ask one of our staff members. Please remember that any changes made to your insurance policy, and the time of year billing is submitted may affect coverage and reimbursement rates.

Deductible and Co-payments are part of you contractual agreement with your insurance company and it is our responsibility as participating providers to collect those fees. **Co-payments are due at each visit.** If your insurance company reimburses more than the billed amounts we will reimburse you immediately upon overpayment.

MEDICARE: Our therapists are participating providers with Medicare, and we will attempt to bill Medicare as well as any supplemental insurance company provided. Physical therapy is a covered service up to $1890 per year, and you are financially responsible for any co-insurance or annual deductible as applicable.

NO INSURANCE / CASH RATE: At SSPT, based on services rendered, discounted rates may apply for patients without insurance or that choose not to utilize their coverage.

RETURNED CHECKS: A $30 NSF (non-sufficient funds) fee will be charged for any checks returned to our office because of insufficient funds. If we receive a returned check, we will notify the patient or responsible party immediately and request that a cash payment be made.

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COLLECTIONS: If your account is more than 90 days past due, without an established payment plan on file, we will begin immediate collection actions. We will begin assessing your account a 3% finance charge, based on your remaining balance, unless you have a payment plan in place. If you do not pay your bill following our internal collection efforts, your account will be sent to an outside collection agency. If your account is sent to a collection agency, you will need to contact them directly to settle your balances.

REFUNDS: A refund is issued when an overpayment have been identified. If you feel a refund is due, please contact us at 215-816-2952.

AUTHORIZATION FOR TREATMENT & FINANCIAL AGREEMENT

I authorize treatment of the patient named below and agree to pay all fees and charges for such treatment. Charges shown on statements are considered to be correct unless notification is received within 30 days of statement date. I agree to pay all charges within 30 days of statement date, unless prior arrangements have been made with the billing office. I agree to assign my insurance benefits to Stillings-Smith Physical Therapy, if applicable.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize Stillings-Smith Physical Therapy to release my health care information or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

I authorize my healthcare providers to release personal health information as it pertains to my rehabilitative care if any is requested by Stillings-Smith Physical Therapy.

AUTHORIZATION TO FILE CLAIM

Should my insurance company fail to comply with state laws and timely filing limits, I authorized Stillings-Smith Physical Therapy to contact the state insurance commissioner to file a claim on my behalf. By filing a claim we can assist the state in identifying problematic situations and companies with a propensity for delaying or selectively reducing claim payment.

AUTHORIZATION FOR COMMUNICATION

I authorize the provider of service to contact me at home or work via phone, cell phone, email, fax, or text for purposes of: appointment scheduling or changing, billing - or questions regarding medical information related to my condition.

Medicare/Supplemental Insurance (if applicable)

I authorize that payment of authorized medicare benefits be made on my behalf to the name of the provider of service and/or supplier of any services furnished to me by that provider or service and/or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents or supplemental insurance agency any information needed to determine these benefits or the benefits payable for related.

I have read and agree to the above information.

Patient Name: _____

_____ _____

Signature of Responsible Party (must be over 18 years old) Date