RELEASE OF INFORMATION/FINANCIAL POLICY

The following is a statement that we require you to read and sign prior to any treatment. All items may or may not apply to your situation. If you would like a copy of this document, please ask for one.

Please check the clinic where you will be attending therapy:

ORS PHYSICAL THERAPY WWW.ORSPT.COM

- ☐ **ORS of Dixon** - (815) 284-1700
- ☐ **ORS of Byron** - (815) 234-5553
- ☐ **ORS of Rockford** - (815) 227-1700

CHC CERTIFIED HAND CENTER WWW.ROCKFORDHAND.COM

- ☐ **CHC - Rockford** - (815) 226-8780

BRS PHYSICAL THERAPY WWW.BRSPT.COM

- ☐ **Belvidere** - (815) 547-4733

Our Mission

Our practice is committed to providing the greater Rockford area with the finest in specialized physical and occupational therapy. Our main goal is to help restore function, improve mobility, relieve pain and/or prevent further injury through patient and family education.

Patient Privacy and Confidentiality

The Healthcare Insurance Portability & Accountability Act (HIPAA) provides for patient privacy and confidentiality. By signing this agreement, you acknowledge receipt of information pertaining to your rights as covered under HIPAA.

Release of Information

By signing this form, you authorize the designated clinic to release and disclose such medical records, information and documentation (including any alcohol or drug abuse data that may be protected by Federal Regulation 42CFR Part 2) as necessary or appropriate in order to process insurance claims and to obtain payment on your behalf. You agree that a photocopy of your original authorization shall be considered equally authentic. If you wish to restrict access, you must request and complete a Request for Restriction of Uses and Disclosures form.

Assignment of Benefits

By signing this form, you authorize assignment of your benefits for treatment and related services to the above designated clinic. This means that your insurance will pay us directly.

Regarding Insurance

As required by your insurance, payment of co-pays is required at the time of service. We cannot guarantee payment by your insurance; however, we do attempt to obtain information about your therapy benefit coverage from your primary payer. If you have a secondary or tertiary insurance, we will not contact them unless your coverage with them is an HMO. Know your benefits. If you have concerns about your coverage, contact your insurance directly. Under the Healthcare Insurance Portability & Accountability Act (HIPAA), we are not allowed to discount or waive patient's co-pays, deductibles or coinsurance amounts as outlined by insurance policies. As a courtesy to all our patients, we file insurance claims directly with your insurance company if you have provided us the information prior to services being rendered. Since your insurance policy is a contract between you and your insurance company, all charges are ultimately your responsibility. Although we make every effort to work with patients when it comes to payments on patient balances, we do utilize an outside collection agency in those instances in which a patient does not show a commitment to paying the balance due. In those instances, patients may be responsible for an additional charge not to exceed 50% of the balance owed.

Usual and Customary Rates (U&C)

We do make every attempt to maintain a fee schedule in line with the value proposition we deliver by reviewing our rates annually to ensure our services are commensurate within our area of delivery. We partner with established networks, professional organizations and government agencies who evaluate our reimbursement schedules and have rewarded us with continuous network renewals. Non-contracted payers may determine coinsurance with regard to their own Usual & Customary fee scale and the difference may be applied to your patient balance.

Personal Injury/Auto Accidents

As a courtesy to you, we will first bill third party payers. For example, timely filing issues can be avoided if there is any third party payer issues. After 45 days, outstanding balances will become patient responsibility.

Returned Check Fee

In the unlikely event that your personal check is returned unpaid by your bank, you will be billed an additional $40 fee for each returned check.

Reprocessing Fee

If at any time you request claims to be reprocessed, you may be assessed a $100.00 reprocessing fee.

Missed Appointments

Please help us serve you better by keeping your appointments. We recognize that, at times, it is not possible to keep appointments. If you are unable to keep an appointment, please call our office at least 24 hours prior so we can make this time available to other patients. We allow 2 instances of less than 24 hours notice or missed appointments without any additional charge. On the third and subsequent instance, we will charge a $25 fee and you will be held responsible for the payment.

Initial: _____

Supply Type Items

Often insurance companies DO NOT cover the cost of items such as shoe inserts, braces, etc.; therefore, the patient becomes responsible for these items. If you are concerned about insurance coverage of these items, please contact your insurance company prior to accepting any of these items. We do offer prompt payment discounts on these items if paid at the time of service.

Acknowledgment

By signing this form, I consent to receive treatment as prescribed by my physician and a qualified licensed therapist of the above designated clinic. I have read and understand the above statements concerning the clinic's expectations and my rights and obligations. I also, hereby authorize assignment of financial benefits directly to the associated clinic for services rendered as allowable. I understand that I am financially responsible for charges not covered by this assignment.

*We reserve the right to amend, change or modify our policies with notice.

_____ _____

Signature of Patient or Responsible Party
if Patient is a Minor

Relationship to Patient

_____ _____

Print name signed above

Date