FINANCIAL POLICY

In accordance with the Federal Truth-in-Lending Act, all Medical Providers are required to give their patients complete information in connection with the extension of credit.

- BASIC POLICY: The patient is responsible for all medical bills in our office. Our staff will help with completion of insurance as accommodation and convenience to you without charge. It is the patient's responsibility to know your contract benefits, assure collection of insurance payments to us, and to negotiate with your insurance company over any disputed claims. The policy holder must follow-up with their insurance company to resolve any issues resulting in unpaid claims older than 60 days.
- INSURANCE: Fill out the patient's section of our form. If you are covered by Medicare, or other insurance please present your identification card to the receptionist at time of appointment.
- WORKMAN'S COMPENSATION: In the event it is determined by the Worker's Compensation board that the illness or injury is not a result of a Worker's Compensation case, 1 hereby agree to pay usual and customary fees for services rendered.
- REJECTED CLAIMS: If your insurance company rejects your claims, or if they pay less than the total bill, our policy requires you to pay the balance in full upon receipt of your statement. If you cannot pay in full after your insurance payment, contact our Business Office.
- FORMS OF PAYMENT: We accept payments in cash, check, and money order, VISA or Mastercard. Checks must be made payable to South Mountain Rehabilitation whose name is on your statement.
- RETURNED CHECKS: A $20.00 handling charge is applied to all returned checks.
- **DELINQUENT ACCOUNTS: Delinquent accounts over 90 days are turned over to our collection manager. If the bill remains unpaid and satisfactory arrangements for payment are not made, the Collection Manager will review the account with the Physical Therapist to decide appropriate action. If your account is referred for collection, you agree to pay all collection fees, and in addition, you agree to pay any attorney fees and litigation costs if legal action is commenced.**
- **MONTHLY STATEMENTS: You will receive an itemized monthly statement until your bill is paid in full whether or not you have insurance. This is a courtesy to you to be aware of the status of payment on your account and have a record or services. Once your insurance has paid you are responsible for the unpaid balance. Interest of 1.5% per month (18% per year) will be applied to any amount not paid after 30 days with a minimum charge of 50 cents per month.**
- If you fail to make your scheduled appointments you may be charged $25.00. Please contact our office 24 hours in advance to make scheduling changes.

Authorization to Release Information

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

Authorization to Pay Benefits

I authorize and direct any insurance companies or attorneys to pay all proceeds of benefits directly to SOUTH MOUNTAIN REHABILITATION for their professional services rendered. I understand this does not release me from my personal responsibility for paying my provider when a statement is rendered.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I have read and agree to the Financial Policy of this office.

Patient ______________________________ Date __________

Insured ______________________________ Date __________