

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, but are for informational purposes only. If you would like a copy of this document, please ask for one.

Please check the clinic where you will be attending therapy:



PHYSICAL THERAPY

WWW.ORSPT.COM

- ORS of Dixon** - (815) 284-1700
- ORS of Byron** - (815) 234-5553
- ORS of Rockford** - (815) 227-1700
- ORS of Roscoe** - (815) 270-0704



CERTIFIED HAND CENTER

WWW.ROCKFORDHAND.COM

- CHC - Rockford** - (815) 226-8780
- CHC - Byron** - (815) 234-5553



PHYSICAL THERAPY

WWW.BRSPT.COM

- Belvidere** - (815) 547-4733

Patient Privacy and Confidentiality

The Healthcare Insurance Portability & Accountability Act (HIPAA) provides for patient privacy and confidentiality. By signing this agreement, I acknowledge receipt of information pertaining to my 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 their balance. In those instances, you may be responsible for an additional charge not to exceed 50% of the balance owed.

Usual and Customary Rates

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. Given our mission, we routinely evaluate our fees to ensure they are consistent with other providers for our area.

Cases Involving an Attorney

If you are receiving services that are related to an auto accident or personal injury and you are working with an attorney, we expect a minimum monthly payment of \$25 due upon receipt of a patient statement.

Returned Check Fee

In the unlikely even that your personal check is returned unpaid by your bank, you will be billed an additional \$25 fee for each returned check.

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.

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.

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.

Signature of Patient or Responsible Party
if Patient is a Minor

Relationship to Patient

Print name signed above

Date