OFFICE AND PAYMENT POLICIES

You, the patient, are our # 1 priority. Our office staff is experienced in dealing with insurance companies and strives to be of service to you in handling claims or solving any problems that may arise. We accept most insurances, including Medicare, as well as workers compensation, auto insurance and self-pay patients.

PAYMENT POLICIES

1. A discount is available to self- pay patients.+
2. The patient is fully responsible for payment of all charges regardless of insurance or lawsuit determination. Payment by cash, check, debit, Visa or Mastercard is accepted. All charges over 90 days are to be paid in full unless prior arrangements are made.
3. Health insurance patients will have a bill sent directly to their primary insurance carrier.
4. We must have a signed Assignment of Benefits on file so payments are made directly to STARS Physical Therapy.
5. Any co-payment required by insurance will be collected at the time services are rendered.
6. When treatment is completed any overpayment on the account will be refunded to the patient and/or the appropriate insurance company.
7. We are an approved Medicare provider and accept assignment. Secondary insurance, if applicable, will be billed as a courtesy to the patient.
8. Personal injury cases are handled in the same manner as our health insurance cases. We will bill insurance on request. If the claim is disputed or denied, the patient is fully responsible for the balance on the account. An attorney lien will NOT be accepted on these cases; however, if another insurance is available we will bill at the time of service with the information provided.
9. Workers Compensation cases will be billed directly to the employer's compensation carrier. Workers Compensation patients will need to provide the correct name, address and adjuster of carrier as well as claim number, employer, date of injury and attorney, if applicable.
10. If you have any questions or problems with regard to payment for services, please do not hesitate to speak to our billing office.

Signature:____ Date:_______________

OFFICE POLICIES

CONSENT FOR TREATMENT AND ADMISSION

I agree to be admitted to STARS PHYSICAL THERAPY as an outpatient and authorized the staff to evaluate and treat within the scope of physical therapy practice as ordered by the referring provider.

Initials:_________________

RELEASE OF INFORMATION

I hereby authorize STARS PHYSICAL THERAPY to furnish medical records, via fax or mail, to my referring provider and insurance company.

Initials:_________________

WORKERS COMPENSATION RELEASE OF INFORMATION

I authorize STARS PHYSICAL THERAPY to discuss/forward any relevant information as related to my rehabilitation, with my worker's compensation carrier/case manager.

Initials:_________________

ASSIGNMENT OF BENEFITS

I hereby assign all of my right, title, and interest to STARS PHYSICAL THERAPY of insurance/health and welfare benefits otherwise payable to me, not to exceed the balance due of STARS' customary charges for the services.

Initials:________________

FINANCIAL AGREEMENT

I assume financial responsibility for the payment of all charges at the time of service unless covered under worker's compensation, Medicare, or a specific insurance carrier. As a courtesy to you, STARS PHYSICAL THERAPY will file your claims to the insurance carrier that you have designated. By initialing below, you agree for your insurance to be filed. All deductibles, co-insurances and co-pays, including non-covered services are your responsibility.

Initials:_________________

CANCELLATION/ NO-SHOW POLICY

As a courtesy to our staff and other patients, we ask that you make every effort to keep your scheduled appointments. If you are unable to keep a scheduled appointment, please call and cancel at least 2 hours prior to the appointment, Unless due to an emergency, failure to cancel the appointment within that time frame will result in the assessment of a $20 per incidence fee.

Initials:__________________

HIPAA ACKNOWLEDGEMENT

I have received the Notice of Patient Information Practices of STARS PHYSICAL THERAPY on today's date.

Initials:____________________

The undersigned certifies that he/she has read the foregoing and is the patient, the patient's representative, or is duly authorized by the patient and his/her agent to execute the above and accept its terms. If patient's condition prohibits written consent, agent who is present when verbal consent is given should sign patient's name by agent's name. If patient is a minor, how old is he/she?_________

Patient/relative/authorized agent signature____

Relationship to patient (if signature is not patient's)____

Witness Signature____