



Release of Information / Financial Policy

Please check which clinic you will be attending therapy.

Please remember to bring your picture ID and insurance cards.

- | | |
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| <input type="checkbox"/> Belvidere Physical Therapy- Belvidere, IL | <input type="checkbox"/> Marengo Physical Therapy- Marengo, IL |
| <input type="checkbox"/> McHenry County Physical Therapy- McHenry, IL | <input type="checkbox"/> Ogle County Physical Therapy- Byron, IL |
| <input type="checkbox"/> Poplar Grove Physical Therapy- Poplar Grove, IL | <input type="checkbox"/> Roscoe Physical Therapy- Roscoe, IL |

Thank you for choosing the clinics of the Orthopedic and Sports Therapy Institute, Inc. as your health care provider. **For the purpose of this form, the Orthopedic and Sports therapy Institute refers to the following clinics: Belvidere Physical Therapy, Inc., Marengo Physical Therapy, Inc., McHenry County Physical Therapy, Inc., Ogle County Physical Therapy, Inc., Poplar Grove Physical Therapy, Inc., and Roscoe Physical Therapy, Inc.** Following is a statement of our Release of Information/ Financial Policy which we require you to read and sign prior to any treatment. All patients must also complete and sign our Patient Registration Form.

Release of Information/ Medical Records Initials _____

By signing this form, you authorize the clinics of the Orthopedic and Sports Therapy Institute, Inc. or his/ her designee(s) to release and disclose such medical records, information and documentation as may be necessary or appropriate in order to process insurance claims and to obtain payment on your behalf. You authorize the release of information acquired in the course of your examination or treatment and all information pertaining to your history and progress in your case. This includes any alcohol or drug abuse data that may be protected by Federal Regulations- 42CFR Part 2. You agree that a photocopy of your original authorization shall be considered equally authentic.

Regarding Insurance Initials _____

We cannot bill your insurance company unless you provide us with your insurance information and any special claim forms required by your insurance company. We accept assignment of insurance benefits. That means your insurance will pay us directly the amount due based upon your benefit coverage. By signing this form, you authorize assignment of our benefits to the clinics of the Orthopedic and Sports Therapy Institute, Inc. for treatment and related services. However, we do require, as your insurance benefits require, payment of co-pays due at the time of service. Your insurance policy is a contract between you and your insurance company. **Please know your benefits. Please be aware that only your insurance company can tell you if the services provided are covered under your benefit plan.**

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. **In the event that your account becomes past due and is turned over to collections, you will be responsible for all cost of collections, including collection agency expenses and fees not to exceed 50% and all cost to file suit including attorney fees and court costs.**

Those Insurance Plans in which we are a Participating Provider.

All co-pays and deductibles are due at the time of treatment. Prior to seeking payment from you, we will work with these plans to obtain payment. In the event that your insurance coverage changes to a new plan in which we are not a participating provider, refer to the paragraph below.

Those Insurance Plans in which we are NOT a Participating Provider.

If your insurance company has not paid your account in full within 45 days of the billed date, the balance is your responsibility. Your assistance in collection from your insurance company may be required.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. The federal government agency that administers the Medicare and Medicaid programs, has determined that except for circumstances, the discounting or waiving or a patient's co-pay or deductible is unlawful. Additionally, under the new HIPPA regulations, we are not allowed to discount or waive patient's co-pays or deductibles as outlined by benefits plans offered by other third party payers. You are responsible for payment unless we are a participating provider for your insurance company.

Patient Balances and Returned Check Fee

Patients are responsible for full payment at the time of service if not covered by some other third party such as Medicare, Medicaid or private insurance. Our returned check policy requires a \$25.00 additional fee for each check returned.

Refunds

Due to the nature of our long-term relationship with our patients, we will issue refunds on a quarterly basis unless a specific request is made.

Cases Involving an Attorney Initials _____

If you are receiving services for an auto accident, worker's compensations case or personal injury and you are working with an attorney, we expect a minimum monthly payment of \$25.00 in order to continue treatment. We also require information relating to your group health coverage. Your group health and the appropriate auto/ worker's compensation carrier will be billed at the same time unless instructed otherwise. This procedure is necessary in order to have a claim on file with the group health in case the auto/ worker's compensation carrier does not pay or is exhausted at some point during your treatment. The procedure not only protects the clinics of the Orthopedic and Sports Therapy Institute, Inc., but you as the patient as well.

Missed Appointments Initials _____

Please help us serve you better by keeping scheduled appointments. We recognize there are times when it is not possible to keep appointments. If you are unable to keep an appointment, please call our office at least 24 hours prior to the appointment time. If you miss a scheduled appointment our policy is to charge a **\$25.00 fee** for missed appointments and you will be held responsible for payment.

Health Insurance Portability and Accountability Act of 1996 (HIPPA)

HIPPA is a protective measure safeguarding patient privacy and confidentiality. By signing this agreement I acknowledge that I have received information pertaining to my rights as covered under the Health Insurance and Portability and Accountability Act of 1996.

By my signature, I consent to receive Physical Therapy treatment as prescribed by my physician and given by a qualified licensed Physical Therapist. I have read and understand the above statements in the Release of Information/ Financial Policy concerning my payment responsibility.

X _____
Signature of Patient or Responsible Party Print Name Date

X _____
Signature of Co-Responsible Party Print Name Date

WE ACCEPT PAYMENT IN THE FORM OF CASH, PERSONAL CHECK, VISA OR MASTERCARD.