Hand & Orthopedic
Physical Therapy Specialists

Murray	Salt Lake City	Draper	Bountiful
801.261.3321	801.328.8535	801.501.8359	801.298.2533

FINANCIAL POLICY

This is an agreement between Hand & Orthopedic Physical Therapy Specialists and the Patient/Responsible Party signed on this form. By executing this agreement, you are responsible for all medical bills and other charges that result from services rendered by Hand & Orthopedic Physical Therapy Specialists.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the provider and is not a substitute for payment. Regardless of insurance coverage you are responsible for all balances incurred. Some insurance companies may pay fixed allowances for certain procedures, sometimes referring to these as "Reasonable and Customary Fees." We do not accept this as payment in full, unless otherwise restricted by law or contract agreement we may have with your insurance carrier(s). Many insurance companies pay only a percentage of the charge, leaving it your responsibility to pay any deductible amount, co-insurance amount, co-pays (due at each visit) and any other balance not covered by your insurance carrier(s). As a courtesy, our office may inform you of the benefits we were quoted by your insurance carrier(s). However, this is not a guarantee of your actual benefit plan or payment. If you have any further questions, please contact your insurance carrier(s).

ASSIGNMENT OF BENEFITS: I hereby assign all medical/physical-occupational therapy benefits, to which I am entitled, Medicare, private insurance and other health plans to: Hand & Orthopedic Physical Therapy Specialists. 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 hereby authorize said assignee to release all information necessary to secure the payment, via fax transmittal or hard copy. Medical records will be accessible to all physical/occupational therapists of Hand & Orthopedic Physical Therapy Specialists.

INJURIES AT WORK: In the event it is determined by your industrial/Worker's Compensation insurance that the illness/injury is not a result of a compensated Worker's Compensation case, you will be responsible to pay usual and customary fees for services rendered. If you do not have your information at this time, please get it to us within 24 hours before your account is turned over to Self Pay status.

AUTO ACCIDENTS: Auto insurance claims will be billed to YOUR auto carrier, not to any other parties' auto carrier due to Utah's No Fault Law. If your auto PIP exhausts, which in many cases is true, as you may have already been to the emergency room, had surgery, etc, we will bill your health insurance that you have provided. If you wish to not have your health insurance billed, you will be responsible for all charges. If you do not have your information at this time, please get it to us within 24 hours before your account is turned over to Self Pay status.

PERSONAL INJURY: If you are dealing with a lawsuit or claim, we require verification from your attorney, as well as a lien agreement that we may keep on file and a monthly payment plan. Please remember even if you have an attorney you are ultimately responsible for your bill and need to update our office on the status of your case frequently.

SUPPLIES: Frequently, therapy supplies and/or splints are recommended to expedite your recovery. Unfortunately insurance companies do not cover these items. Therefore, if your therapist suggests these items, it will be your responsibility and your decision to purchase these items. We will provide you with a receipt to bill your insurance if you choose to do so. Used or opened items are non returnable/refundable. Supplies are to be paid for at the time of service. If we have to bill you for a supply you will incur an extra service charge.

PAST DUE ACCOUNTS: If your account becomes past due, our office will take necessary steps in contacting you to collect this debt. If these attempts do not generate a response from you, your account could be subject to collections. If this account is sent to collections, I agree that in addition to any amount left owing to Hand and Orthopedic Physical Therapy Specialists, I will be responsible for interest at the rate of 18% annually on any past due balance, calculated from the date of service, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee equal to 40% of the past due balance.

RETURNED CHECKS: There is a fee (currently $20) for any checks returned by the bank.

MISSED APPOINTMENT FEE: If you fail to provide 24 hours notice prior to canceling your appointment or fail to show up for a scheduled appointment, a fee of $65.00 will be charged. This fee must be paid before a new appointment is scheduled.

SELF PAY ACCOUNTS: If you do not have health insurance we do offer self pay plans. Self Pay payments are due at the time of service. Please speak to our Patient Advocate or a member of our billing staff for more information. If you are unable to provide us with your health insurance, worker's compensation insurance or personal injury insurance within 24 hours of your first visit you will automatically be turned over to a self pay account status. Even if you provide us with your insurance information after the initial 24 hour period we reserve the right to refuse to bill your insurance.

MONTHLY STATEMENT: If you have a balance on your account, we will send you a monthly statement. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable on or before the due date specified on the statement and is past due if not paid on or before that date. We do charge interest (18%) on all past due accounts; interest will begin accruing once the account becomes 60 days past due.

In signing this agreement, I consent to a therapy evaluation and subsequent treatment provided and directly supervised by a licensed physical/occupational therapist and/or physical/occupational therapy assistant employed by Hand & Orthopedic Rehabilitation Specialists as well as agree to all of the terms and conditions contained herein and the agreement will be in full effect.

Patient's Name: _____

Responsible Party (if not patient or if patient is a minor): _____

Signature: _____ **Date:** _____