Total Care
physical therapy, p.c.

# EXPLANATION OF INSURANCE BENEFITS

(Please complete entirely)

Patient Name:_____ Insurance:_____

Co-Pay:_____ Deductible:_____

CoInsurance / Insured Split: Insurance pays_____% Patient pays_____%

Other:_____

As a courtesy to you, we bill your insurance company for the services you receive at Precision Rehabilitation, LLC. We will also verify your benefits for our services; however, this **is not** a guarantee of payment. We don't accept third party billing.

It is important that you understand your health insurance benefits, so if you have any additional questions, we encourage you to discuss your account with our front office staff.

By signing this document below, I am certifying that I understand the above described explanation of benefits. I understand that I am responsible for any co-payment, deductible or partial split due at each visit.

## PATIENT RESPONSIBILITY

Prescriptions:

Prescriptions are valid for 30 days from the date they are written. We will make sure that you prescription is kept current by either asking your physician to issue a new prescription or having them sign and return progress reports.

Referrals / Authorization / Pre-Certification:

If you insurance carrier requires a referral/authorization/pre-certification, it is your responsibility to obtain the necessary approvals before you begin your physical therapy. When we verify your insurance, we will ask if a referral/authorization/pre-certification is needed and inform you if you do. Without a referral/authorization/pre-certification, your insurance carrier we will not pay for your treatment.

Payment:

Your deductible and co-insurance or co-payments are your responsibility. Also, visits not covered for exceeding benefits or not having referrals or authorizations will be billed to the patient. Ultimately, you are responsible for payment.

## CANCELLATION AND NO SHOW POLICY

Cancellations:

We understand that from time to time you may need to cancel an appointment for various reasons. We allow one missed appointment or no show without a charge. Acceptable excuses for a missed appointment are emergency situations. Please understand that our therapists are in high demand and our schedules are completely full nearly all the time. If you miss a scheduled appointment, it is likely that someone else would have been able to attend therapy at that time.

1) For cancellations that are non-emergencies, 24 hour notice is required.
2) Be prepared to reschedule the missed appointment, within the same week to help keep your treatment plan on track.
3) Cancellations that are made without appropriate notice (24 hours) are subject to a patient charge of $20. This is not covered by your insurance plan and you will be personally responsible for the payment.

No Shows:

1) If you do not show up for a scheduled appointment you will be charged $20. This is not covered by your insurance plan and you will be personally responsible for the payment. We allow you one grace no show.
2) If you have excessive no shows and your therapist feels that your treatment is suffering due to the cancellations, your therapist may recommend alternative care that is more suited to your needs.
3) If you do not show for an appointment and there are extenuating circumstances, please call us so we can handle the situation appropriately.

## ASSIGNMENT / RELEASE / CONSENT:

I certify that I, and/or my dependent(s), have insurance coverage(s) with the insurance company(ies), including those listed above, for which I hereby assign all benefits directly to Precision Rehabilitation, LLC for all health care services provided. I understand that I am financially responsible for all charges whether or not paid by insurance(s). I authorize the use of my signature on all insurance submissions. Precision Rehabilitation, LLC may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

By signing this form I give Precision Rehabiliation, LLC consent to treat me or my dependent(s).

Patient Signature:_____ Date:_____

Signature of Guardian:_____ Date:_____

Witness initials:_____