WELCOME TO ORTHOPAEDIC SPORTS SPECIALISTS PHYSICAL THERAPY

Financial Policies

We have found that communication with our patients regarding our policies assists us in providing the best service to you. Please take that time to carefully read the sections which pertain to you.

PRESCRIPTIONS - Most insurance companies require a valid prescription from a Connecticut Licensed Physician, Dentist, Podiatrist or Nurse Practitioner for physical therapy reimbursement. It is the patient's responsibility to ensure the prescription is up-to-date and valid.

****MEDICARE**-** **A**dhering to Medicare guidelines for physical, speech and occupational therapy, there are financial limitations for therapy services. **The dollar amount for the 2016 limitation from January 1, 2016 through December 31, 2016 is $1,960.** You will be responsible for any therapy services provided beyond the Medicare limitation. **Please initial: __________**

INSURANCE - We are happy to bill your insurance company as a courtesy and convenience if we are provided with appropriate billing information. If we do not receive proper information, payment may be required at the time services are rendered. As a courtesy we will verify your insurance benefits for physical therapy. ***However, we strongly advise you to contact your insurance company directly to obtain this information since it is ultimately the patient's responsibility to know and understand their insurance benefits***.
Please initial: __________

COPAYS, COINSURANCE, DEDUCTIBLES - It is our policy to collect co-pays at the time of service. Co-insurance is an estimated amount and we may not know the exact amount until the claims are processed. Therefore the estimate is based on the *average* patient responsibility. If there is a balance due after your insurance processes we will bill you for the difference between the amount you have paid and what the insurance states is the patient responsibility amount. If you have a deductible which has not been met you may be asked for payment on this as well.
Please initial: __________

NO INSURANCE - We are happy to provide services to patients not participating in a health insurance program, but we must insist payment be made at the time services are rendered.

AGREEMENT/AUTHORIZATION

"I hereby assign, transfer and convey payment and authorize said payment to be made directly to **Orthopaedic Sports Specialists** for any medical benefits, sick benefits, injury benefits due because of liability of a third party, or proceeds of all claims resulting from liability of a third party, payable by any party, organization, etcetera, to or for discharge or completion of all outstanding obligations related to this medical treatment. I further agree that this assignment will not be *withdrawn or voided* at any time until this account is paid in full. I understand that I am responsible for any charges not covered by my insurance company and for deductible and copays. I realize that the provider may be required to release medical information on my behalf for the purpose of obtaining payment, to settle a dispute to facilitate payment and other reasons outlined in our Privacy Policy. **Orthopaedic Sports Specialists** has the right to charge reasonable collection fees and add these fees to my account balance if I fail to pay outstanding charges on my account. The undersigned individually obligates him/her to pay the account of the provider in accordance with the regular rates and terms of the provider:

____ _______________________________

Signature **Date**

Orthopaedic Sports Specialists

HIPAA Contact Information

May we leave a message regarding your **appointment**: (Please circle answer)

Home Phone (include Auto Call)	Yes	No
Mobile Phone (include Auto Call)	Yes	No
Mobile Text (include Auto Call)	Yes	No
Work Phone	Yes	No
With Another Person	Yes	No
Send via Mail	Yes	No
Send via Email	Yes	No

May we leave a message discussing **medical information**: (Please circle answer)

Home Phone	Yes	No
Mobile Phone	Yes	No
Mobile Text	Yes	No
Work Phone	Yes	No
With Another Person	Yes	No
Send via Mail	Yes	No
Send via Email	Yes	No

EMAIL ADDRESS: ____

Please List person(s) authorized to discuss medical information:

Name: ______________________________ Relationship: _______________

Name: ______________________________ Relationship: _______________

Name: ______________________________ Relationship: _______________

Emergency Contact: _____________________________________ Phone #:________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been offered or have received the Notice of Privacy Practices from **Orthopaedic Sports Specialists**

Signature____ **Date**____________________________