CROUSE

REHAB ASSOCIATES

Payment Policy

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We make every effort to verify coverage with your insurance company. In the event your insurance company deems all or part of our charges non-payable, you will be responsible for those charges. To avoid misunderstandings, our business manager invites early discussion of financial problems or questions regarding fees for payment from insurance carriers. You will be responsible for the percentage of the charges that insurance will not cover at the time that services are rendered. If you have more than one insurance policy that will pay for your charges here at our clinic then the following policies will apply:

1. We can only bill one insurance company at a time. If your primary insurance is "automobile" it must be filed first. Upon notification that you PIP coverage is exhausted, private insurance will then be filed for all past and future charges.
2. We cannot accept the responsibility of negotiating claims with insurance medical care within a reasonable time, regardless of the status of a claim.
3. We encourage you to refer to your insurance policy for details, including limitations, regarding your coverage for out patient physical therapy, since we cannot guarantee payment of your claims.
4. Reduction or rejection of your claim by your insurance company, does not relieve the financial obligation you have incurred.
5. We require a signature below on workers compensation claims in the event that the entire claim is controverted. This bill would then be the patient's responsibility.
6. If you prefer to file your own insurance, fees will be payable at the time services are rendered.

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In an effort to keep the rising costs of quality medical care down, it is very important to receive timely payment for services rendered. If collection and/or legal services are required to obtain payment, I agree to pay all costs reasonably incurred including attorney fees, court costs and interest at a rate of 1 1/2% per month.

I understand that I am responsible for payment of services. I further understand that insurance may be filed by your office as a courtesy, and does not constitute a contract between therapist and insurance company for payment of your services. I have read the payment policies as explained on this form and understand my responsibilities.

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Patient or authorized person (signature) Date

I authorize the release of any medical information necessary to process the attached claim for services rendered. I further authorize payment of medical benefits directly to the therapist. Photo static copy of this authorization shall be considered as effective and valid as the original.

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Patient or authorized person (signature) Date