



Patient Name:

DOB:

Acct #:

Date:

Thank you for choosing Back-in-Action Rehabilitation as your therapy provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Consent to Treat.** You are authorizing Back-in-Action Rehabilitation to provide treatment, release information pertaining to your treatment for insurance purposes, and/or receive direct insurance payments for services rendered. You acknowledge that no guarantees have been made as a result of any therapy treatments or evaluations administered or prescribed by our clinic, nor can they be. You understand that although you may be discharged from treatment, it is your responsibility to seek follow-up care when necessary and that your condition may continue to require maintenance therapy.
3. **Maintenance Therapy.** Maintenance therapy is particularly applicable to patients with chronic, stable conditions where skilled supervision and intervention is no longer required and further clinic improvement cannot reasonably be expected for continuous ongoing care. Most insurances do not cover maintenance therapy. This can be discussed with your therapist, to explore other options such as private pay.
4. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please pay your co-payment or deductible at each visit. Payments can be made by cash, check or credit card.
5. **Non-covered services or items.** Please be aware that some of the services, or therapy items, you receive may not be covered by insurers. You must pay for these services in full at the time of visit.
6. **Proof of insurance.** All patients must complete our patient information form before seeing the therapist. We must also obtain a copy of your insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claims.
7. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
8. **No Insurance.** We will provide therapy services on a cash only basis if you request. Payment must be made at the time of your visit.

9. **Credits on Account.** If any excess funds remain in your account, you hereby authorize Back-In-Action Rehabilitation to apply any excess funds to any other outstanding accounts you may have with Back-In-Action Rehabilitation.
10. **Returned Checks.** A \$25 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
11. **Nonpayment & Collections.** You are required to remit the balance due on your account when services are rendered. Any portion of your bill which has remained unpaid for six months after the date of initial billing may be turned over to an attorney or collection agency. If your account is referred to an attorney, all additional attorney's fee and collection expenses will become your obligation to pay. Account balance is due in full, partial payments will not be accepted unless otherwise negotiated.
12. **Missed appointments/Late Cancellations.** Our policy is to charge \$25 for missed appointments not canceled within a reasonable amount of time (24-hour notice). These charges will be your responsibility and billed directly to you; they are not covered by insurance. Please help us to serve you better by keeping your regularly scheduled appointment. When cancelling your appointment, you must inform the staff of the reason for cancellation – if deemed to not be an emergency, your account will be charged \$25 for the missed appointment.
13. **Privacy Notice.** By signing below, you are acknowledging that you have had full opportunity to read and consider the contents of our Privacy Notice.
14. **Medical Records.** Payment of reasonable costs will be necessary if you request photocopies of your medical records and reasonable time will be afforded to the clinic to respond to such requests. Costs are updated annually pursuant to Wis. Stat. §146.83.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our policies. Please let us know if you have any questions or concerns.

By signing below, you certify that you have read the entire document, understand its contents and significance, accept responsibility for payment, and agree to abide by its guidelines:

DATED this _____ day of _____, 20_____.

Signature: _____ Witness: _____

If patient is a minor or unable to consent, complete and sign the following:

Patient is unable to sign because
(provide reason) _____

Signature: _____

Person signing on behalf of patient

Relationship to patient

Witness: _____

