Medical Assignment of Benefits & Financial Policy

Please read and initial each the following. Sign and date at the bottom.

The team at Spooner Physical Therapy is pleased to be part of your rehabilitation experience, and we thank you for choosing us. We believe that communication with our patients regarding our financial policy assists in providing the best service to you.

*****The American Medical Association recommends positive identification of all patients in an effort to prevent insurance fraud and identity theft. You will be asked to provide your Social Security number and photo ID for insurance purposes.***

******We will gladly call your insurance company to obtain your current benefit coverage. However, insurance companies will not guarantee medical benefits or payment over the phone. We can only use this information as a guideline.***

- I understand that I have medical insurance which, when billed on my behalf, will (should) pay for my office visits (therapy). ______ initial
- I understand this process may take 4-8 weeks. At that time my insurance company will determine and pay for services according to my insurance plan benefits. ______ initial
- I understand it is my responsibility, and agree, to pay all copays, co-insurance, deductibles, or “cash pay” estimated amounts at the time of service. ______ initial
- I understand that a copy of my explanation of benefits (eob’s) will be sent to me by my insurance company when the claims are processed. ______ initial
- I understand that it is my responsibility to pay all uncovered services within 30 (thirty) days after my insurance has paid their portion. ______ initial
- I understand that if for any reason my insurance company does not pay for the covered services within 90 (ninety) days of the services provided, I shall assume responsibility for the total amount owed. ______ initial
- I understand that if my account balance is not paid within 30 (thirty) days from the date of my final statement, that a $50 collection fee and other fees allowed by law will be added to my account. ______ initial
- I understand that if my account balance is not paid within 30 (thirty) days from the date of my final statement, that my account may be referred to a collection agency. ______ initial
- I thereby assign all medical benefits to Spooner Physical Therapy. ______initial
- I authorize Spooner Physical Therapy to release my medical information to insurance companies, physicians, attorneys and to all other pertinent parties that may be involved in my claim or care. ______ initial

I have read and understand this document and all of my questions have been answered.

____
Patient Name (please print)

____ ____
Patient Signature (parent or legal guardian) Date