PAYMENT POLICY AND BILLING PROCEDURES

1. YOU are responsible for the percentage, copay and/or deductible not covered by your insurance company. This payment is requested during each visit.
2. If insurance information is not available, or you do not have insurance, payment is due in full unless other arrangements have been approved by our financial manager.
3. You will receive a monthly statement which will show you the status of your account.
4. There will be a $25 charge for all returned checks.

INSURANCE INFORMATION

As a courtesy to our patients, we will verify and file your insurance; however, we can not guarantee payment. We strongly suggest that you read your policy manual as it pertains to physical therapy coverage. Many insurance companies have stipulations, such us usual and customary fees (UCR), limited therapy sessions, limited reimbursable amounts per session, deductibles, co-payments, supplies, etc. Such stipulations should be indicated in your policy manual.

YOU ARE RESPONSIBLE FOR AMOUNTS NOT COVERED BY YOUR INSURANCE. We have an agreement with YOU, not your insurance company for receipt of payment. Please be aware of this and plan to make payments accordingly. Worker's compensation will be verified; however, this does not guarantee payment. In the event of denial, this account will become YOUR RESPONSIBILITY.

CONSENT TO TREATMENT

I understand that I have been referred for rehabilitative treatment and care to QUALITY REHABILITATION NETWORK. QUALITY REHABILITATION NETWORK will describe for me my individual treatment plan. I understand that I have the right to ask and have any questions answered prior to receiving my treatment, including any risks or alternatives to the treatment plan that has been prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have QUALITY REHABILITATION NETWORK provide treatment and care as prescribed by my physician and/or recommended by my therapist.

The statements are true and complete to the best of my knowledge. I understand, fully, the payment policy and billing procedures of QUALITY REHABILITATION NETWORK. I hereby authorize QUALITY REHABILITATION NETWORK to furnish my insurance company(s), attorney, or legal representative all information which said parties may request concerning my present illness or injury. I hereby assign QUALITY REHABILITATION NETWORK all money to which I am entitled for medical expenses related to the service reported herein, but not to exceed my indebtedness to QUALITY REHABILITATION NETWORK. It is understood that any money received from the above named parties over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to QUALITY REHABILITATION NETWORK for charges not covered by my insurance company. I certify by my signature that I have read and agree to this information.

Patient Signature_____Date_____

Parent or Guardian (If applicable)_____Date_____