ADVANCED
HAND & PLASTIC SURGERY CENTER

- ☐ Private Insurance
- ☐ Medicare
- ☐ Worker's Comp
- ☐ Self Pay

OCCUPATIONAL/HAND THERAPY

~FINANCIAL AGREEMENT~

Date:_____ Name:_____, _____
(LAST) (FIRST)

Address: _____

City:_____State:_____Zipcode:_____

Day time phone: (_____)_____

Email:_____

Insurance

If you have medical insurance and are eligible for Occupational Therapy Services, our staff at Advanced Hand Plastic Surgery Center, LLC will work with you and your insurance to maximize your allowable benefits. In order to achieve this goal, we need your assistance and your understanding of our payment policy and highly encourage you to familiarize yourself with the terms, conditions and limitations of your insurance contract as well.

You will be asked to update your personal and insurance information periodically, including providing our practice with copies of your insurance card, especially when your information and/or insurance changes. We are required by law and the terms of your insurance contract to adhere to the terms outlined in your agreement. Our failure to obtain these updates could result in criminal and civil penalties and/or expulsion from your insurance plan. Please comply and assist us with your insurance requirements.

_____**Please initial**

After each visit with the therapist, qualified services and treatments are submitted to your insurance company for payment. We expect payment of services within 60 days. However, it may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days. It is your responsibility to understand your coverage and benefits, including deductibles, referral and authorization requirements, pre-certifications, maximum number of visits or maximum dollar amount limits, co-insurance, co-payment, and out of pocket fees including all contractual exclusions and your member status on the date of service. If you provide us with false and knowingly give us wrong information, you will be responsible for all charges incurred.

_____**Please initial**

Deductibles

Your deductible, if applicable to your plan, as of _____/_____/_____, is $_____.____, of which you have met $_____.___. The deductible is the amount of money YOU HAVE TO PAY before your insurance will pay for services rendered. **Your insurance deductible is your financial responsibility**. This is stated your insurance contract agreement.

_____Please Initial

Copayments and/or Coinsurance

Your fee per visit and subsequent scheduled appointments, is $_____. The coinsurance amount is an estimate of the fee you have to pay for occupational therapy services after you have paid any applicable deductible.

We accept cash, checks, and all major credit cards. **OUR FAILURE TO COLLECT THESE AMOUNTS MAY BE A VIOLATION OF OUR CONTRACT WITH YOUR INSURANCE COMPANY**. In addition, your failure to pay the required co-amounts is a violation of your financial responsibility for coverage and we may report your refusal to your employer and/or insurance company commissioner.

_____Please Initial

Out-of-Pocket Costs & Maximum

This amount refers to the most you have to pay in deductibles and/or coinsurance for covered medical services. Depending on your plan design and agreement, the out-of-pocket costs may or may not include copayment amounts. **Your out-of-pocket maximum, if applicable to your plan, as of _____/_____/_____, is $_____.____, of which you have met $_____.___.** Please reference your insurance contract agreement for specific guidelines concerning deductibles, copayments and coinsurance.

_____Please Initial

Missed Appointments

Your cooperation in canceling your scheduled appointment allows us the opportunity to offer your time slot of 45 minutes to a person who needs to be seen by the therapist for treatment. Failure to keep your scheduled and confirmed appointment will result in a **$25 cancellation fee**, due along with any other charges at the next scheduled visit.

_____Please Initial

Past Due & Delinquent Balances

It is your obligation to maintain your account in good standing. As a general rule, "All estimated payment responsibility (coinsurance, copay and/or deductibles) is **Due Prior to Services Rendered**." For services billed that are your financial responsibility, payment is due upon statement receipt. If payment is not received by the third statement notification, and we have exhausted our resources in attempting to collect the debt, your delinquent balance is reviewed and subject to collection efforts.

_____**Please initial**

If you have any questions about the information listed, please do not hesitate to ask to speak with our billing manager. Your insurance is a contract between you, your employer and/or the insurance company. We are not a party of that contract. We must emphasize that as a medical care provider, Advanced Hand and Plastic Surgery Center, LLC, our relationship is with you, not your insurance company. We realize that temporary financial problems may affect timely payment of your account and/or continuation of treatment. If such problems do arise, you are encouraged to contact us promptly for assistance in the management of your account.

My signature below constitutes acknowledgement and acceptance of this financial agreement between Advanced Hand and Plastic Surgery Center, LLC and myself.

Signature:_____Date:_____
(Patient or Guardian: Person financially Responsible)

Patient's Name-(printed):_____

Reviewed by (OT/billing only):_____Date:_____