Wasatch Physical Therapy

Financial Policy

- As a courtesy to you, Wasatch Therapy will file your medical insurance claims. We will gladly try to answer any questions related to your insurance, but because insurance plans are so varied, we cannot tell you what your costs will be for your office visits. Your individual plan determines your coverage, any requirements for prior authorizations or referrals and establishes the limits on your coverage and medical services. We are not party to that contract except where we are contracted as preferred providers.

- As a physical therapy practice, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from the date of service rendered. **Therefore, it is often necessary for you to inquire and explore your benefits with your insurance carrier.** We realize that temporary financial problems may affect timely filing of your account and if such problems do arise, we encourage you to contact our billing office for assistance in the management of your account. It is also your responsibility to provide your correct/updated insurance information to Wasatch Therapy.

- **Financial/Insurance Responsibility**: I (the undersigned) understand that payment is required at or before each visit. I am responsible for charges incurred for all treatment rendered. This responsibility includes co-pay, co-insurance, deductible amounts, non-covered and excluded items not paid for by my insurance carrier or other party responsible for coverage of my medical expenses. I agree I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I further understand, Wasatch Therapy will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Wasatch Therapy to take action to secure payment of an outstanding balance owed. I understand that all accounts sent to a collection agency will be charged an additional 33.33% collection fee as allowed by Utah Code.

- **Referral Authorization:** I understand that it is my responsibility to obtain all necessary referrals prior to therapy. If my insurance carrier requires an authorization for service, no service will be rendered until the authorization is obtained.

- **Patient Responsibility Costs**: I agree to promptly pay my personal account balance including co-insurance or unmet deductible upon receipt of my statement. I understand and agree that responsibility for payment for services rendered is mine, due and payable unless other financial arrangements have been made. The terms of this agreement shall apply to all amounts incurred by me or by any individual for whom I have legal responsibility whether such amounts are incurred today or after today.

- I have read, understand, and agree to the above Wasatch Therapy Financial Policy. I understand that I am responsible for all charges whether or not paid by said insurance. I understand that Wasatch Therapy does not accept liens. If I am working with an attorney for payment or if my insurance carrier denies payment due to injury being work or auto related, I understand that I am responsible for the balance of my account for any professional service rendered. I acknowledge that these policies do no obligate Wasatch Therapy to extend credit.

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Patient Name	Signature of Patient or Authorized Representative	Date

HIPAA Patient Consent

➔ Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. <u>You have the right to review our Notice of Privacy Practices before signing this Consent.</u>

➔ You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

➔ By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. We provide this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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Patient Name	Signature of Patient or Authorized Representative	Date