

FINANCIAL POLICIES

Please carefully review our Financial Policies. It is important for you to have a thorough understanding of your therapy benefits and responsibilities.

INSURANCE COVERAGE: As a service to our patients, Dunbar Therapy Center is more than happy to directly bill your insurance for services rendered, but it is our policy that the patient is ultimately responsible for payment of the services received from DTC. Furthermore, the patient is responsible for understanding their insurance coverage in relation to covered services and is responsible for providing DTC with the most current insurance information.

Our clinic and therapists participate in the majority of regional health plan networks allowing you the benefit of “in-network” coverage. We make every attempt to verify your current insurance coverage. Verification of benefits is NOT a guarantee of payment. Information we collect includes: effective dates, deductibles, co-payments and co-insurance amounts. Please remember that any changes made to your insurance policy, and the time of year billing is submitted may affect coverage and reimbursement rates. We do not routinely research why an insurance carrier has not paid or why it paid less than anticipated.

DEDUCTIBLES AND COPAYMENTS are part of your contractual agreement with your insurance company and it is our responsibility as participating providers to collect those fees. Co-payments are due at each visit. If your insurance company reimburses more than the billed amounts we will reimburse you immediately upon identifying overpayment.

MEDICARE: Our therapists are participating providers with Medicare, and we will attempt to bill Medicare as well as any supplemental insurance company provided. Occupational therapy is a covered service up to \$1940 per calendar year. Physical and speech therapies have a combined covered service up to \$1940 per calendar year. You are financially responsible for any co-insurance or annual deductible as applicable.

WORKER’S COMPENSATION AND MOTOR VEHICLE ACCIDENT: It is your responsibility to provide us with the name and address of the insurance carrier along with your claim number. If we do not have verifiable billing information before your second appointment, your therapy will continue either on a cash basis until we receive the necessary billing information pertaining to your injury, or we obtain private insurance information. If, for any reason, your claim is denied, we will attempt to bill your private health care insurance, but please understand that ultimately you are responsible for full payment. Any attorney “letter of protection” for claims being disputed or in litigation will be discussed on a patient-by-patient basis and will not always be an acceptable form of payment guarantee. If that is the case we will need alternate insurance information or we can transfer your account to a cash pay basis. If your claim is in a “deferred” status we will need to have private insurance information on file in the event your claim is denied or pending litigation.

NO INSURANCE / CASH RATE: We believe that no one should be denied physical therapy services due to lack of insurance coverage. Our clinic offers a discounted cash rate to those who do not have appropriate insurance coverage. Payment will be required at the time of service unless arrangements are made in advance. Please inquire about our current cash pay rate if it is applicable to your situation.

SUPPLIES: Some supplies are not covered by insurance and you may be asked to pay a small fee for these services. These will be explained to you and you will have the opportunity to “opt out” of the service before incurring a charge.

CANCELLATION POLICY: Dunbar Therapy Center requires a 24 hour notice for the cancellation of a scheduled appointment. Failure to do so will incur a \$25 charge to your account which is not covered by your insurance

company. If you feel ill, wary of road conditions or an emergency should arise please contact us as soon as possible.

RETURNED CHECKS: A \$30 NSF (non-sufficient funds) fee will be charged for any check returned to our office because of insufficient funds. If we receive a returned check, we will notify the patient or responsible party immediately and request that a cash payment be brought to our office within 24 hours to replace the full amount of the check.

COLLECTIONS: If your account is more than 90 days past due, without an established payment plan on file, we will begin collection actions. If you do not pay your bill following our internal collection efforts, your account will be sent to an outside collection agency. If your account is sent to a collection agency, you will be charged a \$50 administrative fee that will be added to your account.

REFUNDS: A refund is issued when an overpayment have been identified. If you feel a refund is due, please contact our billing office at 304-948-1076.

AUTHORIZATION FOR TREATMENT & FINANCIAL AGREEMENT

_____ I authorize treatment of the patient named below and agree to pay all fees and charges for such treatment. Charges shown on statements are considered to be correct unless notification is received within 30 days of statement date.

_____ I agree to pay all charges within 30 days of statement date, unless prior arrangements have been made with the billing office.

_____ I agree to assign my insurance benefits to Dunbar Therapy Center, if applicable.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ I authorize Dunbar Therapy Center to release my health care information or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

_____ I authorize my healthcare providers to release personal health information as it pertains to my rehabilitative care if any is requested by Dunbar Therapy Center.

HIPPA NOTIFICATION

_____ I acknowledge that I have reviewed and been given a copy of this office's *Notice of Privacy Practices*.

I HAVE READ AND AGREE TO ALL OF THE ABOVE INFORMATION

Patient Name: _____ Date _____

Signature of Responsible Party (must be over 18 years of age) _____

****For minors being dropped off****

I hereby authorize Dunbar Therapy Center's therapists consent to examine and treat the above mentioned minor without a Parent or Guardian present.

Signature: _____