FINANCIAL POLICY AND AGREEMENT

Thank you for choosing Applause Hand Therapy for your therapy needs. This office is committed to providing the highest quality care. The following is an explanation of our office policy and agreement, which we ask you to read prior to any evaluation or treatment. All patients need to complete the information and medical history forms before seeing our therapists.

- Each patient is responsible for his or her own bill.
- Payment of all insurance co-payments and deductibles are required at the time service is rendered.
- Patients who have no insurance are required to pay 100% of services rendered each visit, unless other arrangements have been made. We accept cash, check, Visa, or MasterCard.
- Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Therefore, it is the patient's responsibility to determine what the insurance company will allow for occupational therapy and obtain approval if necessary. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.
- We do participate with most insurance companies; however, some plans require a referral from the primary care physician. A written referral and any required pre-authorization must be on file prior to each office visit. It will be your responsibility to contact your insurance carrier to confirm pre-authorization and to extend the number of visits approved.
- A $40.00 fee will be charged on all returned checks.
- Any responsibility balance older than 60 days is subject to an interest charge of 1% per month.

INITIALS _____

LATE CANCELLATIONS AND NO-SHOWS

Cancellations or changes must be made 24 hours in advance of the scheduled appointment. If a patient fails to show or cancels two scheduled appointments, treatment will be discontinued.

INITIALS _____

MEDICAL SUPPLIES AND ORTHOTICS

Many insurance companies do not consider medical supplies a covered benefit. Therefore, we ask for payment in full at the time of pick-up if you are purchasing a non-covered item. We accept cash, check, Visa, or MasterCard.

INITIALS _____

PATIENT CONSENT AND RELEASE

I understand that Applause Hand Therapy is not responsible for any personal belongings that I bring into the clinic. I understand that I am financially responsible for all charges for services rendered regardless of litigation, insurance reimbursement, or pending L&I claims. I understand that the parent accompanying a minor for treatment will be responsible for payment. I authorize Applause Hand Therapy and its subsidiaries to release any necessary information requested by my insurance carrier and authorize payment directly to Applause Hand Therapy and its subsidiaries for any benefits available under my insurance plan. I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of treatment, including testing and/or treatment for Sexually Transmitted Diseases, AIDS or HIV Infection, Alcohol and/or Drug Abuse, or Mental Health Conditions.

HIPPA NOTICE

I acknowledge receipt of the HIPPA Notice of Privacy Practices for Applause Hand Therapy.

INITIALS _____

I HAVE READ AND ACKNOWLEDGED THE ABOVE STATEMENTS WITH MY INITIALS AND SIGNATURE BELOW.

SIGNATURE _____ **DATE** _____

(If patient is a minor (under age 18) , parent or guardian's signature required)