**Release of Information/Financial Policy**

The following is a statement that we require you to read and sign prior to any treatment.

All items may or may not apply to your situation, but are for informational purposes only. If you would like a copy of this document, please ask for one. Please initial when indicated.

**Patient Privacy and Confidentiality**

The Healthcare Insurance Portability & Accountability Act (HIPAA) provides for patient privacy and confidentiality. By signing this agreement, I acknowledge receipt of information pertaining to my rights as covered under HIPAA.

**Release of Information**

By signing this form, you authorize Helping Hands Rehab to release and disclose such medical records, information, and documentation as necessary or appropriate in order to process insurance claims and to obtain payment on your behalf. You agree that a photocopy of your original authorization shall be considered equally authentic.

**Assignment of Benefits**

By signing this form, you authorize assignment of your benefits for treatment and related services to Helping Hands Rehab. This authorizes your insurance to pay Helping Hands Rehab directly.

As a courtesy to all our patients, we file insurance claims directly with your insurance company if you have provided us the information prior to services being provided. Since your insurance policy is a contract between you and your insurance company, all charges are ultimately your responsibility. We cannot guarantee payment by your insurance; however, we do attempt to obtain information about your therapy benefit coverage from your primary payer. If you have a secondary or tertiary insurance, we will not contact them unless your coverage with them is an HMO. If you have concerns about your coverage, contact your insurance directly.

As required by your insurance, payment of co‐pays is required at the time of service. Under the Healthcare Insurance Portability Accountability Act (HIPAA), we are not allowed to discount or waive patient’s co‐pays, deductibles or coinsurance amounts as outlined by insurance policies. Although we make every effort to work with patients when it comes to payments on patient balances, **we do utilize an outside collection agency in those instances in which a patient does not show a commitment to paying their balance**. In those instances, you may be responsible for an additional charge not to exceed **50%** of the balance owed.

**Missed Appointments**

\_\_\_\_\_We recognize that, at times, it is not possible to keep appointments. If you are unable to keep an appointment, please call our office at least 24 hours prior to the appointment time. If you do “no show” or cancel appointments, you will be discharged after 3 of these missed appointments. We automatically discharge you after a month of non-treatment. You would need to obtain a new order from your doctor to be seen again.

**Usual and Customary Rates**

Helping Hands Rehab is committed to providing specialized therapy. We routinely evaluate our fees to ensure they are consistent with other providers in our area. Under HIPAA, we must bill all patients/insurances the same amount. We do offer a self-pay rate of $90.00 per visit that must be paid at the time of service.

**Cases Involving an Attorney**

\_\_\_\_\_We require the name and phone number of your attorney as well as a copy of your health insurance card at the time of registration. This is necessary to avoid timely filing issues with the health insurance in case the auto/personal injury carrier does not pay or is exhausted at some point prior to final payment. This procedure protects both you as the patient and us as a provider from potentially large balances.

**Returned Check Fee**

\_\_\_\_\_\_In the unlikely event that your personal check is returned unpaid by your bank, you will be billed an additional $25 fee for each returned check.

**Illness or Infection**

We request in cases of illness or contagious infection you do not attend therapy. We may ask you to wear a face mask if you are displaying signs of infection. As with the transmission of any communicable disease, such as, but not limited to: Flu, colds, Covid-19, etc. you may be exposed to these diseases at any time or place. Be assured that we follow state and federal regulations and recommended universal precautions and disinfection protocols to limit transmission of all diseases. By signing this form, you agree to accept the risk of disease transmission and agree to absolve Helping Hands Rehab, Inc, for any disease or infection that you may acquire while receiving treatment at Helping Hands Rehab.

By signing this form, I consent to receive treatment as prescribed by my physician, by a qualified and licensed therapist at Helping Hands Rehab. I have read and understand the above statements concerning the clinic’s expectations and my rights and obligations.

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Signature of Patient or Responsible Party Relationship to Patient if Patient is a Minor

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Print name signed above Date