INSURANCE VERIFICATION

Date: _____ **Initial Eval Date:** _____

Patient:_____ **Patient Phone #:**_____
DOB:_____ **Member ID**:_____
Primary Insurance: _____ **Portal:**_____
In Network: Yes/No **Prior authorization required**: Yes/No

We have made contact with your insurance carrier and at this time they have indicated the following:

Deductible: _____ **Met**: _____
Out-of-Pocket: _____ **Met:** _____
Co-pay:_____
Coinsurance: _____
Coinsurance Rate: _____ (payable at each visit) ****ESTIMATE****

Number of visits allowed per calendar year: _____ **Hard Limit:** Yes/No **Number of visits used:_____**

Reference Name/#:_____

****

Do you have a Secondary Insurance: YES/NO **If Yes, Name of Insurance:** _____

Have you received OUTPATIENT physical/occupational therapy within this calendar year? Yes/No
If yes, how many visits_____

Are you currently receiving Home Health: Yes/No

If you had Home Health within the past week, what date did this end: _____

Is this related to an Auto accident: Yes/No
If yes, we bill YOUR insurance company. We DO NOT bill other responsible parties.

Your Insurance Company:_____
Policy #:_____
Claim Number:_____
Contact Person:_____
Contact Person Phone Number:_____ **Fax Number**:_____

As a courtesy, Whitewater Valley Rehabilitation verified your benefits with your insurance company. A quote of benefits is not guarantee of benefits or payment. If you are covered by health insurance with PT benefits, we will be happy to bill your insurance. Your claim will process according to your plan. If your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received.

****Please be advised that if you DO NOT provide us with the appropriate insurance information OR you fail to update it with us, your insurance company may not cover services and you will be held financially responsible for all charges incurred.**

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It is our company policy that payment is due at time of service unless other financial arrangements are made in advance**. We require all patients to pay their deductible, co-pay, and/or coinsurance payments at the beginning of each visit.** At the conclusion of your visits, you will be billed for any outstanding balance. You will be held accountable for any unpaid balances by your plan. If there is a credit, you will be provided a refund.

If you are being seen due to an accident of any type (ie: Auto, slip/fall at a store, etc.), we strongly encourage you to use the liability insurance associated with the accident. Please be sure to provide us with your Auto/Home Owner's policy information and contact person. If you choose to use your personal health insurance, you are assuming responsibility and therefore will be held responsible for any claims denied due to not using the appropriate liability insurance.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by a physician does not guarantee that your insurance will cover our services. We highly recommend you contact your insurance carrier and check into your coverage for physical/occupational therapy. ***Do not assume that you will not owe anything if you have more than one insurance policy.

Please remember that you are 100% responsible for all charges incurred. Your physician referral and our verification of insurance benefits are not a guarantee of payment.

I hereby I assign my insurer to make payments directly to Whitewater Valley Rehabilitation for all basic benefits as well as major medical benefits herein specified and otherwise payable to me for the charges for this treatment period.

*****PATIENT STATEMENTS WILL BE SENT BY EMAIL ON THE 15th OF EACH MONTH. IF YOU DO NOT HAVE AN EMAIL ADDRESS, A STATEMENT WILL BE MAILED TO YOU. YOU MAY ALSO RECEIVE OTHER EMAILS REGARDING YOUR ACCOUNT PERIODICALLY THROUGHOUT THE MONTH.*****

Emails will come from CSS BILLING. Our contact is Elizabeth and her email address is elizabeth@cssbilling.com. Her phone number is 303-429-1086 if you need to get in contact with her. Her business operates on Central time.

Patient signature:_____ Date:_____

Authorization for Release of Information: I understand that Whitewater Valley Rehabilitation will release any medical information acquired in the course of my evaluation and treatment to any referring physician or any workman's compensation case manager. This facility makes every attempt to maintain your confidentiality and will not forward any information without a signed release.

Liability Acknowledgement: This is to verify you have been made aware that physical or occupational therapy techniques and exercises may cause an inflammatory response to joints, muscles, and surrounding tissue which you may not be directly treated for. It is normal to experience an increase in pain, discomfort, or even soreness with exercise and therapy techniques due to inflammation from your current injury or surgery. You may also experience these symptoms in body parts not being directly treated secondary to deconditioning, lack of use prior to injury, other surgeries, or inflammatory conditions which you have been diagnosed. In the event that severe increased pain may arise in any body part, you are responsible for relaying this information and the manner in which it happened (i.e.: work, home, recreation to your therapist so your treatment program can be modified. We are not responsible for injuries occurred due to negligence of the patient or improper use of exercise equipment. Our goal is to make your rehabilitation at our facility a pleasurable experience, and with your help we will be able to accomplish that.

Medicare/Medicaid: We will bill Medicare and any secondary insurance you have. You will not receive a bill from us until your claims have been processed by insurance. You are responsible for co-pays, coinsurance, or deductible that your insurance does not pay. You may also be responsible for payment if Medicare denies any therapy services that you have received.

Commercial Insurance: This is a contract between you and your insurance company. We will bill your insurance as a courtesy to you. It is up to you to know your policy and what they pay and who is in your network. If they require a referral that is also up to you to obtain this. Anything that is not covered by your insurance, you may be billed.

Auto/Personal injury: If you're being treated as part of an auto/personal injury lawsuit or complaint, we will be happy to bill your auto/homeowners insurance. It is your responsibility to provide us with this information. Please be aware that you are responsible for any balance not paid by your insurance company.

***<u>If you have a change in your insurance and you fail to inform us of this change, you will be financially responsible for all bills.</u>** We will attempt to re-bill claims once updated insurance information is provided to us, however, that is not a guarantee of payment. Some insurance companies require prior authorization in order for you to attend therapy. Most insurance companies will not let us get what is called a retro-prior authorization. Therefore, it is your responsibility to make sure we have the correct insurance information on file. Please help us comply with your insurance company's policy and prevent you from receiving unexpected bills.

Return Checks: There is a $25 fee for any return checks by the bank.

No-Shows/No Calls: If you no showed 3 times, we will consider you discharged and will not schedule you again. Our time is valuable. Therefore, a $25 fee per no show will be assessed and billed to you.

By signing below, you agree to all terms and conditions contained within this agreement.

Printed name:_____

Signature:_____ **Date:**_____

HIPAA Compliance Patient Consent Form

Our notice of privacy practices provides information about how we may use or disclose protected health information.

The notice contains a patient's right section describing your right under the law. You ascertain by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revokation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to remote this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or sending text message to confirm appointments? Yes No

May we leave a message on your answering machine at home or on your cell phone? Yes No

I authorize my medical information/records to be released to or discussed with the following individuals:

1. _____
2. _____
3. _____

Patient Name:_____

Patient Signature:_____ Date:_____

How Did You Hear About Us?

(circle all that apply)

- Doctor Referral
- Google/Internet Search
- Facebook
- Friend/Relative
- Previous Patient
- Radio
- Our Company Website
- Phonebook
- Newspaper
- Billboard
- Other _____