Prism Performance
&
Physical Therapy

400 Summit Dr., Lockport, IL 60441 ~ 815-838-9441

Financial Policies

Thank you for choosing Prism Performance and Physical Therapy for your rehabilitation needs. We appreciate that you have entrusted us with your health care and are committed to providing you with the best patient care possible. Please carefully read through the following financial information.

Because healthcare benefits and coverage options have become increasingly complex, we have developed these policies to help you better understand your responsibility as a patient and eliminate any unnecessary confusion. We will do our best to assist you with understanding your proposed treatment and in answering questions related to submitting your insurance claim for reimbursement. Adhering to these policies will enable us to focus increased attention on providing quality rehabilitative services to our patients an run our clinic more efficiently.

If you have any questions in regards to the following information please do not hesitate to ask any of our staff members.

UPDATES: It is important that we have your correct information on file. Please advise us anytime there is any change to your address, telephone or other contact information. If you are issued a new insurance card please allow us to take a copy of it for your file. If your insurance changes or discontinues mid-treatment, please notify us immediately so there is no delay in billing.

PATIENT PRIVACY: Prism Performance and Physical Therapy is committed to protecting the privacy and security of our patients and all Protected Health Information (PHI). During the course of treatment, it may be required to share information with other medical providers. We follow all Federal and State laws and regulations regarding PHI and information will only be released with written authorization of the individual in question. This written authorization may be revoked at any time by the individual as provided by law. If you have any questions, please contact one of our staff members. If requested, we can provide you with a copy of our "Statement of Privacy Notice".

INSURANCE COVERAGE: As a service to our patients, Prism Performance and Physical Therapy 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 PP and PT. Furthermore, the patient is responsible for understanding their insurance coverage in relation to covered services and is responsible for providing PP and PT with the most current insurance information.

Our clinic and therapists participate in several major 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. We will try and review this information with you at your next visit. If you are unfamiliar with any of the terms used to explain your insurance benefits, please don't hesitate to ask one of our staff members. 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 don't routinely research why an insurance carrier has not paid or why it paid less than anticipated.

Deductible and Co-payments 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 billed amounts, we will reimburse you immediately upon overpayment.

MEDICARE: Our therapists are participating providers with Medicare, and we will attempt to bill Medicare as well as any supplemental insurance company provided. Physical therapy is a covered service up to $2230 per year, and 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 transfer your account to a cash pay basis. If your claim is in a "deferred" status we will need to have a 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 secondary to lack of insurance coverage. Our clinic offers a discounted cash rate to those who do not have the 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.

RETURNED CHECKS : A $30 NSF (Non-sufficient funds) fee will be charged for any checks 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 one of our locations within 24 hours to replace the amount of full amount on the check.

COLLECTIONS: If your account is more than 90 days past due, without an established payment plan on file. We will begin immediate collection actions. If you do not pay your bill following our internal collections efforts, your account will be sent to an outside collection agency. If your account is sent to a collection agency, you will need to contact them directly to settle your balance.

NO SHOW/CANCELLATION: We realize that emergencies are going to happen and are unavoidable at certain times. However, please provide a 24-hour cancellation notice or appointment change. If you do not cancel or change your appointment, we have the right to charge for the scheduled appointment. After missing 3 appointments without cancellation notice, you will be discharged from physical therapy unless other arrangements have been discussed with your therapist. Thank you for your cooperation and understanding. By signing below, you will agree and accept the terms and conditions of this policy.

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 chares within 30 days of statement date, unless prior arrangements have been made with the billing office. I agree to assign my insurance benefits to Prism Performance and Physical Therapy, if applicable.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize Prism Performance and Physical Therapy 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 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 Prism Performance and Physical Therapy.

AUTHORIZATION TO FILE CLAIM

Should my insurance company fail to comply with the state laws and timely filing limits, I authorized Prism Performance and Physical Therapy to contact the state insurance commissioner to file a claim on behalf. By filing a claim we can assist the state in identifying problematic situations and companies with propensity of delaying or selectively reducing claim payment.

I have read and agree to the above information

_____

Patient Name

_____ . _____

Signature of Responsible Party (must be over 18 years old) Date

_____