

Insight Institute of Neurosurgery & Neuroscience (IINN)

Jawad A. Shah M.D. P.C.

Insight Physical Therapy and Neuro-Rehab Center

4800 S. Saginaw St. • Ste. 1800
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Phone: (810) 732-8336

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FINANCIAL POLICY

The following Financial Policy has been set forth by Dr. J. Shah M.D., Dr. B. Mehta M.D. as well as the other providers employed by IINN (hereinafter referred to as "we" or "us"). It is required that the patient and/or responsible party (hereinafter referred to as "you") read and sign this statement prior to any treatment.

SELF PAY - A mandatory payment is due prior to treatment from all uninsured patients. Monthly payments are required until your balance is paid in full. We accept cash, check, money orders and MasterCard, Visa, Discover and American Express card payments.

INSURANCE - We reserve the right to accept or deny assignment of insurance benefits. If we accept assignment of benefits, it is your responsibility to supply our office with a copy of your current insurance card. Please remember that your insurance policy is a contract between you and your insurance company. The balance on your account is your responsibility. Please keep in mind that some, and perhaps all, of the services provided may be non-covered services. Also be aware that some services may not be considered reasonable and/or medically necessary by Medicare or other medical insurance. Regarding insurance plans where we are participating providers, **all co-pays are due at time of service**. In the event that your insurance coverage changes to a plan where we do not participate, please refer to the information in the above paragraph.

WORKER'S COMPENSATION - You must complete and sign a "Worker's Compensation Case" form. It is your responsibility to bring this completed form with you along with all billing information for your account (carrier name and address, contact person, telephone number and claim number). This information must be provided to us prior to treatment. We will not accept a delay in payment due to a worker's compensation dispute and/or litigation. If that is the case, we require a payment plan until a decision is reached. At that time, if the decision is favorable to you, we will attempt to collect payment from them for any outstanding bills that pertain to the treatment of your injury. We will reimburse you for any payments made that your Worker's Comp claim backdates. If the decision is not favorable, we will bill your medical insurance. In the case that you do not have medical insurance or it is past the time limit to file a claim with your medical insurance, you will be held accountable for your full balance.

AUTO/LIABILITY INJURY - If you are being seen due to a liability injury you must provide the following information for billing and verification of payment prior to treatment:

***Auto Accident:** if you were injured in an auto accident, you must complete and sign an "Auto Case" form and provide us with the name and address of the auto insurance company responsible, your agent/adjuster's name, telephone number, your claim number and date of accident. You must also state whether the auto insurance is primary to your medical insurance or not and the litigation status of your claim.

***Slip and fall, etc.:** you will be required to submit the info pertaining to your case i.e. lawyer's contact info, insurance company responsible and their contact info.

For any case, we will not accept a delay in payment due to a claim that is in dispute and/or litigation. If that is the case, we reserve the right to bill your medical insurance until a decision is reached. If your medical insurance denies payment due to an open Auto/Liability claim, you will be required to set up a payment plan and make payments until a decision is reached. If the decision is favorable, we will attempt to collect payment from them for any outstanding bills that pertain to the treatment of your injury. We will reimburse you for any payments made that your Auto claim backdates. Your medical insurance will be reimbursed, if they have made payments, once your Auto/Liability insurance has paid. If the decision is not favorable, we will bill your medical insurance if we have not already. In the case that you do not have medical insurance or it is past the time limit to file a claim with your medical insurance, you will be held accountable for your full balance.

MINOR PATIENTS - The following parties are responsible for payment of the minor's account balance: the adult accompanying the minor and/or the parents (or guardians of the minor). A minor that is not accompanied by an adult will be denied any non-emergency treatment unless charges for the treatment have been preauthorized.

ASSIGNMENT OF BENEFITS AND RELEASE OF RECORDS - You do hereby assign to us, the medical benefits to which you, or your dependents, are entitled. You also authorize us to furnish to your insurance company all of your patient information, including but not limited to, any and all medical records, notes, test results, x-ray reports, MRI reports or other documents related to your treatment (including itemization of any charges and payments on your account) that is deemed necessary to process this claim. You also authorize us to release any and all patient information and medical records, necessary to collect this debt. Similarly, you authorize us to contact your insurance company, lawyer, or anyone else directly affiliated with your claim in order to collect this debt.

DISABILITY PAPERWORK FEES - There is a charge of \$25 for each disability document filled out. The paperwork will be completed within 7 business days. Your paperwork will not be released to you, or otherwise appropriate party, until the \$25 fee is received.

RETURN CHECK FEES - There is a \$20.00 service charge on all return checks that will be your responsibility to pay in addition to the original charges the check was for.

COLLECTION COSTS AND PROCEDURES - If your account becomes delinquent, you agree to pay any additional charges to collect your unpaid bills, including but not limited to, reasonable attorney fees, court costs and collection agency fees. By signing this policy you do acknowledge that we reserve the right to release any patient information and any medical records to our collection agency that are deemed necessary to assist their staff and their attorneys in the collection of this debt.

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FINANCIAL POLICY SIGNATURE PAGE

By signing below you confirm that you have read and understood our Financial Policy on the previous page, and that you agree to its contents.

Signature of patient or responsible party

Date

ATTENDANCE POLICY:

Your regular attendance and participation in Physical Therapy is important. Without your participation, physical therapy will not be effective.

As a courtesy to other patients, we may refuse treatments for patients that arrive more than 15 minutes past their scheduled appointment time. Those who are late may be rescheduled for the next available appointment time.

Missing or canceling 3 or more appointments, within 2 weeks, without making up the missed appointments in a timely manner, will result in discharge from physical therapy for non-compliance.

Your doctor and insurance company will be notified of your poor attendance and noncompliance.

***We request 24 hours advance notice of any cancelled or rescheduled appointments.**

Worker's Compensation Patients:

Please be advised in the event that you miss a schedule appointment and fail to notify us, we are obligated to notify your worker's comp adjustor of poor attendance (missed appointments or tardiness).

I agree to actively participate in physical therapy including the following:

- Obtaining current prescriptions and referrals from my doctor, nurse, or medical practitioner.
- Check with my insurance company regarding my individual coverage for physical therapy.
- Ask questions if you do not understand any treatment, care, or instructions the therapist is giving you during physical therapy.
- Performing exercises at therapy as well as at home on a regular basis.
- Payment of any co-payments prior to services, deductibles, or co-insurance.

I understand that I am responsible for my own health care and will actively participate in Physical Therapy. My signature below indicates I have read and agree to the policy.

Patient's Signature _____

Date: _____

Staff Initials: _____