FINANCIAL RESPONSIBILITY & ATTENDANCE POLICY Date: ____ /____ /____

Thank you for choosing Palmetto Rehabilitation Specialists to be your physical therapy provider. To ensure the best possible service, the following information is provided to help you better understand your rights and responsibilities as our patient.

Covered Benefits: As a courtesy, we will verify eligibility and file claims to your insurance carrier. We cannot, however, guarantee payment. You are responsible for payment of any deductible, co-payment/co-insurance or any non-covered service as determined by your insurance coverage. If your insurance carrier denies your claim, or if you or your physician elects to continue therapy past your allowed/approved visits, payment will be expected from you at that time. Verification is only an explanation of benefits and not a guarantee of payment for services provided. Please contact your insurance carrier directly to confirm your individual benefits for *outpatient physical therapy performed in an office.*

Non-Covered Services: The cost of any services you elect to receive that your insurance does not cover will become your financial responsibility. This includes, but is not limited to, Iontophoresis treatment and therapy supplies (i.e. Therabands, Shoulder Pulleys).

Co-payments: Co-payments must be paid at each therapy visit according to your insurance contract. We accept cash, checks and credit cards (Visa, MasterCard and Discover). Please plan accordingly as you will be asked to remit payment at each time of service.

Secondary Insurance: As a courtesy, we will verify eligibility and file claims to your secondary/supplemental insurance carrier. We cannot, however, guarantee payment. You are responsible for payment of any deductible, co-payment/co-insurance or any non-covered service as determined by your insurance coverage. If your insurance carrier denies your claim, payment will be expected from you for the remaining balance from your primary insurance.

Non-Insured: If you do not have insurance coverage, you will be responsible for 100% of the billed charges. We offer a "self-pay" rate which is a discounted rate given as a courtesy to offset some of the cost typically picked up by an insurance carrier. The initial evaluation is $100 and any additional visit will cost $75. This must be paid at the time of service.

Returned Checks: You will be charged a $25 fee if your check is returned from your financial institution due to insufficient funds. This payment is due upon notification from Palmetto Rehabilitation staff.

Payments: Unless other arrangements are approved by the office manager, the balance on your account is due as soon as the claims are processed. For your convenience we accept cash, check, Visa, MasterCard, American Express, and Discover. If you are a current patient, payments are expected at each visit to ensure that a balance does not accumulate. If you have already been discharged from our care, your payment is expected when the statement is issued.

Monthly Payment Plans: Interest-free financing is available upon request. The minimum monthly payment is 10% of the balance on the account and is due on the agreed upon date. These will be handled on an individual basis and must be approved.

Past Due Accounts: If your account becomes past due, we will take necessary action to collect this debt. If we are forced to refer your account to a collection agency, you agree to pay all of the collection cost. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees including court cost. In case of a suit, you agree the venue shall be York County, South Carolina.

Waiver of Confidentiality: You understand that if this account is submitted to an attorney and we have to litigate in open court or if a past due balance is referred to a collection agency, the fact that you have been treated in our facility may become a matter of public record.

Litigation: Patients that are receiving physical therapy due to a personal injury law suit or claim and who have retained an attorney are required to inform PRS at the Initial Evaluation. We will file all claims with your health insurance and all balances are the patient responsibility. If a Letter of Protection is signed by the patient and attorney, we will hold all patient responsibility until a settlement is reached.

Workers' Compensation: We require approval/authorization by your employer and/or workers' compensation carrier prior to the Initial Evaluation. If your claims are denied, you will be responsible for payment in full.

Divorce/ Separation: In case of separation or divorce, the party responsible prior to separation or divorce will still remain responsible. In the case of a minor, the parent that was responsible will remain responsible and if the divorce decree requires that the other parent pay all or part of the balance then it is the responsibility of the parents responsible to collect from the other parent. We will not change the original information in the record.

Medical Records: You will need a request in writing and a signed authorization for us to release your medical records. The requestor will be charged a reasonable copying fee in order to have the medical records sent to an attorney, doctor office or other organization. The fee is dependent on the number of pages that we need to copy. There is a $15 clerical fee associated with each request and then pages 1-25 are .75 each, pages 26-100 are .50 each and pages 101+ s are 0.25 each.

Attendance Policy: You are allotted a specific time and date for each of your therapy appointments in order to meet the needs of your rehabilitation program. We required at least 24 hour notice for all cancellations in order to avoid an associated action. If you cancel or no show for more than 2 appointments then you will be removed from the schedule and your referring physician will be notified. . We understand that there may be times in which this amount of notice cannot be given. These circumstances will be dealt with on an individual basis by the Office Manager

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I have read the above statement and it is my understanding that I am financially responsible to Palmetto Rehabilitation Specialists for providing rehabilitative services to me, or the above named patient. I authorize my insurer to pay any benefits directly to Palmetto Rehabilitation Specialists. I agree to pay PRS the full and entire amount of all charges incurred by me, or the above named patient, or any portion not covered by the insurance carrier.

Patient Signature:_____ Date:_____

Guarantor's Signature (if patient is a minor):_____ Date:_____