Patient Financial Responsibility Form

Patient Name: _____
Date: _____

We are pleased and honored that you and/or your referring physician have trusted us with your care. We hope that after your first visit you will feel valued and well taken care of. Our highly trained staff members at STAR Physical Therapy strive to do their best to make your experience pleasant. As part of this relationship, we wish to review expectations of your financial responsibility as outlined in our Financial Policy.

This policy applies to all clients and specifies responsibility regarding payment for services rendered.

1. AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize STAR Physical Therapy, Inc. to release medical information acquired in the course of my examination or treatment to my insurance company, other payer or other health care providers required to participate in my care.

2. CONSENT FOR COMMUNICATION: I authorize the release of appointment information left in voicemail, email or text message and understand that there is some level of privacy risk associated with these forms of communication.

3. **FINANCIAL RESPONSIBILITY:** STAR Physical Therapy and it's representatives are pleased to assist with submitting your physical therapy claims to your insurance company for payment, however, according to State and Federal regulations, the management of your insurance contract is your responsibility.

I understand that with the exceptions listed below, I am personally responsible for any medical fees I will incur with STAR Physical Therapy. I also understand that | will be responsible for any charges incurred by not providing the most current, correct insurance information to STAR Physical Therapy.

*Exceptions to this policy are those patients with a current authorization with an HMO, a State or Federally funded program, or a PPO in which STAR Physical Therapy, Inc. is currently a contracted provider. If for any reason my insurance denies my claim for expenses incurred after maximum allowance or due to termination of coverage, I understand that I will be responsible for any remaining charges.

4. PROMPT PAYMENT: I agree to pay balances due in a timely manner, If amounts due are not paid within 30 days, I agree to pay a $50.00 late fee. Should my account be referred to a Collection Agency, I will be responsible to pay costs of collection. This includes all legal fees and a 30% fee on all outstanding balances sent to collection.

I understand that if an insurance representative gives the STAR representative incorrect benefit information, I will be responsible for the amount stated upon the processing of my insurance claim, as it is my responsibility to manage my health insurance. Verification of benefits is done as a courtesy, but is not a guarantee of payment. Payment is based on benefit allowance.

I understand that if I have Medicaid, I will give the STAR representative my Medicaid information at my first visit, otherwise, I am opting out of using Medicaid.

I have read, understand, and agree to all of the **above policies and procedures**

Signature of Patient/Guardian:_____

Date: _____

Signature of Front Desk Representative: _____

Date: _____