FINANCIAL ACKNOWLEDGEMENT

Decatur Physical Therapy & Sports Medicine is committed to caring for our patients. If you have medical insurance, we will help you get the most out of your insurance benefits. To reach this goal, we need your help.

- Our staff will help you by sending in an insurance claim form, as payment for your therapist's care.
- We have made every effort to determine if the care you receive here will be covered by your insurance company, to understand the benefit they will pay, and to communicate that clearly to you. We rely on information from you and your insurance company to estimate your financial responsibility. We are not responsible for errors in that information.
- It is important to understand that payment for services is due when you receive treatment, unless payment arrangements have been made.
- Your insurance plan is a contract between you, your employer and the insurance company. We have nothing to do with that contract. Please call your insurance company if you have questions about your benefits.
- All services may not be covered by all insurance contracts. We have made every effort to insure that we only provide services that are covered by your insurance company. If your doctor has ordered services that we know are not covered, we will advise you. You are responsible for charges not covered by your insurance company.
- If your insurance requires that you have a referral from your primary care doctor, you must insure that your insurance company has that referral on file.
- If your check is returned you will have to pay a returned check charge of $35, which is what our bank charges us, in addition to any fees that your bank may charge you.
- Our fees are within the range most insurance companies accept; they are considered usual, customary and reasonable by most companies.

We know financial problems can affect the on-time payment of your account. If this happens, call us at 404-297-9315 for help.

Signed: _____ *Date:* _____

CHARGES FOR SUPPLIES AND ACCESSORIES:

In the course of therapy, you may require therapy items or "supplies" to perform treatments or home exercises. Your insurance does NOT cover supplies, and the patient must purchase them. Our office acquires supplies at the best price possible and sells them for a nominal price, to cover the item and shipping costs.

Examples of necessary supplies include:

- Electrodes for Electrical Stimulation, which is a commonly performed therapeutic treatment. For your safety, our office dedicates a set of electrodes to you exclusively. Cost is around $5.
- To perform exercises at home, you may need an Exercise Band ($3), theraputty ($5) or a shoulder pulley (around $15.)

We regret that insurance companies have shifted the burden of this expense to patients, and we are committed to keeping these costs low.

ASSIGNMENT OF BENEFITS

I hereby instruct _____ Insurance Company to pay Decatur Physical Therapy & Sports Medicine, electronically or by check.

- If my insurance policy prohibits direct payment to the physical therapist, I hereby instruct and direct you to make the check payable to me and mail it to Decatur Physical Therapy & Sports Medicine at the above address.
- For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to Decatur Physical Therapy & Sports Medicine, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.
- A photocopy of this Assignment shall be considered as effective and valid as the original.
- I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.
- I authorize the provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

By signing below, I acknowledge and agree that I have read or had this form read to me and I understand and agree to its contents.

Signed: _____ *Date:* _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Our commitment is to serve our patients with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information. During the course of serving your interests it may be necessary to share information with other health care providers, insurance companies, billing services, family members, and others involved in your case.

We are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law.

- I have read and understand the above notice of Privacy Practices.
- I have read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact you to obtain a current copy of the Notice of Privacy Practices.

Signed: _____ *Date:* _____