General Policies

Thank you for choosing Comber Physical Therapy & Fusion Chiropractic for your rehabilitation needs. We appreciate that you have trusted us with your health care, and are committed to providing you with the best patient care possible. Please carefully read through the following policy information.

Because healthcare benefits and coverage options have become increasingly complex, we have developed these policies to help you better understand your responsibilities 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 your care. Adhering to these policies will enable us to focus increased attention on providing quality care to our patients and run our clinics more efficiently.

If you have any questions in regard to the following information, please do not hesitate to ask.

UPDATES: It is important that we have your correct information on file. Please advise us anytime there is a change to your address, telephone number, or other contact information. If you are issued a new insurance card, please allow us a copy of it for your file as soon as possible. If your insurance changes or discontinues mid-treatment, please notify us immediately to avoid a delay in billing.

PATIENT PRIVACY: Comber Physical Therapy & Fusion Chiropractic is committed to protecting the privacy and security of our patients. 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 private health information. 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 by law.

INSURANCE COVERAGE: As a service to our patients, Comber Physical Therapy & Fusion Chiropractic 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, should your insurance not cover. Furthermore, the patient is responsible for understanding their insurance coverage in relation to covered services.

Our clinic and therapists participate in the majority of regional 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 prior to the start of your treatment. In rare cases, we may not be able to obtain this information prior to your first visit. If you are unfamiliar with the terms used to explain your insurance benefits, please don't hesitate to ask us to clarify. 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 do not routinely research why an insurance carries 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. We have no authority over your deductible or co-payment amounts, nor can we change or waive those amounts. **Payments due are required to be paid at each visit.** If your insurance company reimburses more than the anticipated amounts and you have overpaid as a result, we will reimburse you the overpaid amounts.

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 statement are considered correct unless notification is received within 30 days of statement date. I agree to pay all charges within 30 days of statement due, unless prior arrangements have been

CONSENT FOR TREATMENT IN A GROUP SETTING

Comber Physical Therapy & Fusion Chiropractic, in compliance with Federal HIPAA Regulations, is committed to protecting your health information and privacy. Our therapists and staff will be making every effort to ensure that your protected health information is kept private. However, due to the nature of the open setting of our therapy clinics, certain aspects of your treatment may be performed in the presence of other individuals. In some instances, it is possible that other patients, family members or friends, and our staff will overhear general information relating to your treatment, diagnosis, or benefits. We will do our best to ensure that any private or strictly confidential information is shared with your in a private area.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize Comber Physical Therapy & Fusion Chiropractic to release my health care information or other information pertinent to my case to any insurance company, adjuster, or attorney involved in my case, for the purpose of processing claims and securing payment of benefits.

AUTHORIZATION TO FILE CLAIM

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

MISSED APPOINTMENT POLICY: If a patient schedules an appointment and fails to show up or cancels the appointment less than 24 hours in advance, they will be issued a $25 no-show fee.

A $50.00 cancellation fee will be assessed to all specialized appointments including Women's and Men's Health with Dr. Cheryl Jones, Kristin Rosler MSPT, and Fusion Chiropractic Acupuncture missed appointments. A copy of our detailed missed appointment policy will be given to you at your first visit. **INITIAL: _____**

RETURNED CHECKS: A $30 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 repay the amount due in additional to the fee.

BENEFICIARY/COLLECTION AGREEMENT: If your health insurance company denies payment for any reason, you agree to be personally and fully responsible for payment of any non-covered services, deductibles, co-payments, or any other balance not paid by the insurance company for professional services that were rendered on each date of service. Should the account become delinquent after 45 days of non-payment, a collection process may be utilized at which time a collection fee of 33.3% will be assessed.
INITIAL: _____

_____ _____

Signature of Patient or Legal Guardian Printed name of Patient

_____ _____

Date Witness Signature