DREVNA HUDSON
PHYSICAL THERAPY

700 Eden Rd
Lancaster, PA 17601
Phone: (717) 569-4184
Fax: (717) 569-4192

PATIENT POLICIES AND AUTHORIZATIONS

APPOINTMENTS:

- Please arrive for your initial appointment 10 minutes early
- If you are more than 15 minutes late for your appointment without contacting us your treatment may need to be adjusted or your appointment rescheduled.
- Please wear comfortable clothing that allows for ease of movement of the affected area and appropriate footwear to all therapy appointments.
- Inform the receptionist immediately of any demographic changes (Phone number, address, insurance etc.). Failure to notify us of changes to your insurance coverage and/or financial status may result in you being responsible for payment of services not covered by your insurance carrier.

PATIENTS UNDER 18 YEARS OF AGE:

- The parent(s) or guardian(s) accompanying a minor are responsible for providing current demographic and insurance information for the minor as well as payment for services rendered.
- In compliance with HIPPA regulations we are unable to discuss details of services rendered or to produce an itemized bill for any parties that are not the patient unless previously approved.
- Both parents/legal guardians are responsible for payment for services rendered to the minor patient.
- Parent(s) or guardian(s) must have an Authorization for Medical Treatment form signed each time a minor arrives unaccompanied for an appointment.

INSURANCE INFORMATION: We must emphasize that our relationship is with you, **not** your insurance company. Submission of insurance claims is a courtesy we extend to our patients but all charges are ultimately the patient's responsibility.

- It is our policy to verify each patient's therapy benefits with their insurance company prior to their initial visit and to notify the patient of their coverage. Your coverage is a contract between you and your insurance company. It is important that you contact your insurance company directly with any questions for clarification and final decisions regarding your benefits. The patient is responsible to notify our office of any change in their insurance coverage.
- If you have insurance coverage under a plan with which we do not participate you will be given the option to receive care as a self- pay patient. If you choose to use out of network benefits you need to be aware that any balances not covered by your insurance company become your responsibility.
- You may be asked to sign an Advance Beneficiary Notice for certain services if we believe they may not be covered by your insurance
- Co-pays are due at the time of service. Any deductible or co-insurance amounts due from you will be billed to you. If you receive more than one type of service on the same day you may be responsible for more than one copay.
- **HOME HEALTH –** must be discharged prior to receiving out-patient physical therapy. This means ALL providers must be out of the home and episode is closed before insurance will consider payment.

SELF PAY PATIENTS:

- We offer a reasonable discount for our cash paying patients. We will give you an estimate of your expense and payment for services is due at the time of service.
- You will be asked to sign a waiver that you have no health insurance and will not be filing with any insurance carrier.

TURN OVER FOR ADDITIONAL INFORMATION – SIGNATURE REQUIRED

PAYMENT: Drevna Hudson Physical Therapy is committed to providing you with the best care possible. If you have medical insurance we will do everything possible to assist you in receiving your maximum insurance benefit. In order to achieve this goal we need your assistance and understanding of our payment policy.

- We Accept cash, personal check, money order, Visa, Mastercard, and Discover in person or by mail. Credit card payments are also accepted by phone.
- Any outstanding balances are due within 30 days unless prior arrangement have been made.
- We will be happy to discuss with you any questions you may have concerning a bill.
- PAYMENT PLANS: Please contact our billing department to work out a payment plan with our practice. We will be happy to work with you in order to pay any balance due to our practice.
- All balances that reach 90 days or older from the date of service may be sent to a collection agency. Accounts referred to a collection agency will be subject to a collection fee of 20% which will be added to the total balance due at the time the account is turned over.

CANCELLATION POLICY:

A fee of $20.00 may be imposed for appointments missed or cancelled with less than 24 hours notice. Consistency of treatment is important to the success of therapy, therefore, three consecutive missed appointments may result in discontinuation of treatment. Cancellation fees must be paid prior to any additional services being provided by our office.

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CONSENT TO CONTACT:

I agree that Drevna Hudson Physical Therapy and/or our agents may contact you by telephone at any phone number associated with your account, including wireless numbers for appointment reminders, to service your account or to collect monies you may owe. We may also contact you by sending text messages or emails using any email address you provide to us. Contacts may include prerecorded/artificial voice messages and/or the use of automatic dialing devices as applicable.

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PAYMENT AGREEMENT:

I agree that I am responsible for payment of charges which are not covered, allowed, or paid by my insurance company, Medicare, or any other Fund or third party payor.I accept the fee charged as a legal and lawful debt and agree to pay said fee and any/all collection agency fees, attorney fees and/or court costs. I understand that I will not be responsible for payment of any charges that Drevna Hudson Physical Therapy is restricted from collecting by law or agreement. With the assignment described in this consent I understand that any check for payment of benefits sent directly to me belongs to Drevna Hudson Physical Therapy and that it is unlawful for me to use or apply the funds in any other way.

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CONSENT FOR TREATMENT:

I hereby give my consent to receive treatment at Drevna Hudson Physical Therapy and authorize its employees to treat me in ways they judge beneficial to me. I understand my care may include evaluation, testing, and treatment. I understand Drevna Hudson Physical Therapy cannot predict or guarantee the outcome of this care.

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ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION:

I hereby assign and authorize payment directly to Drevna Hudson Physical Therapy for all rights and interests to which I may be entitled under any insurance policy, Medicare, Fund or third party payor responsible for payment of my benefits. A photocopy of this assignment shall be considered as effective and valid as the original.

I authorize Drevna Hudson Physical Therapy Associates to release all information including all or part of my medical records to my insurance company, employer (workmen's compensation only), Medicare, or Fund or third party payor which may be responsible for payment of my benefits.

I authorize Drevna Hudson Physical Therapy to obtain medical records and/or professional information from my physician or other medical professionals as it relates to my treatment.

_____________________initials

I have read and fully understand the patient policies and authorizations set forth by Drevna Hudson Physical Therapy and I agree to the terms of this policy.

_____________ ____ ______________________________________

Date Signature of Patient or Responsible Party Relationship to Patient