NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health insurance information. I underatand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, 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 office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:____

Signature:____

Relationship to Patient:____

Date:____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was nable to do so as documented below.

Date:	Initials:	Reason:

THERAPY GUIDELINES

- ✓ Welcome to Spectrum Rehabilitation. In order for you to obtain optimal benefits from your treatment program, it is essential that you attend each scheduled visit. You will not gain maximum benefit from your therapy without consistent follow-up and treatment; this could delay your recovery. **A parent or guardian must accompany a minor on the initial visit.**

- ✓ The frequency of your appointments is determined by your physician and therapist based upon your injury. **Please allow at least one hour for your initial visit and wear loose, comfortable clothing.** (A sports bra for females may be more comfortable, shorts are helpful for knee and back injuries.)

- ✓ Appointments should be scheduled at least one week in advance. If you cannot keep your scheduled appointment**, please call at least 24 hours in advance to cancel and reschedule. If you are 15 minutes late for an appointment or if you fail to attend a scheduled appointment without previously cancelling/rescheduling, you will be considered a "no-show".**
    - If you are a Workers' compensation patient, your employer and adjuster will be notified that you did not attend your scheduled therapy visit.

- ✓ It is our clinic's policy that 3 no-shows and/or cancellations may result in cessation of therapy and the need to consult with your physician prior to resuming therapy**. It may also result in a no show fee of $35 being applied to your account.** If your employer insists on keeping appointments during non-working hours, inform us of this on your first visit, so we can accommodate your schedule.

- ✓ Alcohol and non-prescribed substances are not allowed on the premises. If you have been drinking alcohol or using non-prescribed drugs before your treatment, you will not be allowed in therapy.

- ✓ For safety reasons, children, other family members, or friends are not allowed in the treatment areas but are welcome to have a seat in our waiting area. We regret that we are not able to accommodate children who require supervision. For their own safety, please make alternative plans.

- ✓ Please, understand that payment is due at the time of service unless other arrangements have been made.

- ✓ *I understand that I have been referred for rehabilitative treatment and care to a Spectrum Rehabilitation, Inc. clinic. I understand that I have the right to ask and have any questions answered prior to or at any time during my treatment, including any risks or alternatives to the treatment plan. By signing this agreement, I consent to have Spectrum Rehabilitation, Inc. provide treatment and care as prescribed by my physician and/or recommended by my therapist.*

I UNDERSTAND AND AGREE WITH THE ABOVE GUIDELINES TO PARTICIPATE IN MY RECOVERY.

Signature:____ Date:____________________

Witness:____ Date:____________________

FINANCIAL POLICY AND PATIENT AGREEMENT

We are committed to providing you with the best possible care. We expect in return that you show us the same commitment to your medical and financial responsibilities. Your clear understanding of our Financial Policy and Patient Agreement is important to our professional relationship.
As a courtesy to you, we will attempt to find out what your benefits will be. However, all insurance companies specify that the information they provide to us does not guarantee payment or that the amount of patient responsibility will be the same after claims have been processed. Services not covered or deemed not medically necessary by your plan will be your responsibility. We strongly encourage you to call your insurance carrier in order to understand your outpatient physical therapy benefits. Your insurance company may or may not agree with the UCR (usual, customary and reasonable) charged for our local area. Your benefit plan may not cover all services or may deny payment for all services. You are responsible for any remaining balance on your account once your insurance has processed your claim.
Cancellation Policy: In order to meet the needs of all our patients, please call us immediately if you have to reschedule your appointment. If you fail to cancel or reschedule within 24 hours of your appointment time, you will be billed a $25 cancellation fee.

- A quote of benefits is not a guarantee of payment. You are responsible for the financial guidelines laid out in your insurance plan. Coverage is contingent upon your eligibility at the time of service.
- If a referral is required by your insurance carrier it is your responsibility to obtain one from your primary care physician or referring physician.
- ***Insurance Filing*** We will file all claims with your primary and supplemental insurance carriers. However, you need to provide us with complete and accurate personal and insurance information. Failure to do so may result in denial of claims by your insurance company. In which case, you will be financially responsible for the outstanding balance.
- According to the terms of your insurance plan, you are responsible for any predetermined co-payments.
- If we have an agreement with your insurance carrier, we will receive direct payment for covered services. After your insurance company has paid their portion of your claim, you will be billed for the outstanding financial responsibility (including co-insurance and/or deductible)
- ***Billing Service*** If you wish to discuss your account and/or set-up a financial arrangement please contact our billing company at Peak Medical Management, LLC. We accept cash, checks or credit cards (Visa and MasterCard) as forms of payment. There will be a $25 service charge on all returned checks.
- Failure to pay or adhere to agreed payment plan may or may not result in the account being turned over to an outside collection agency. You agree to pay all reasonable legal expenses necessary for the collection of any debt, including reasonable attorney fees.
- ***Billing Statements*** Our billing statements are mailed monthly. We allow 60 days for your insurance company to respond to your claim. If they have not responded in that time frame, we will send you a bill for the outstanding amount and ask that you begin making payments on your account while you and Spectrum resolve any payment issues with your insurance carrier.
- ***Attention Medicare Patients*** For the 2011 calendar year, Medicare has a $162 deductible. Once deductible is met, Medicare covers services at 80% and you are responsible for a 20% co-insurance. All secondary insurances to Medicare may pick up a portion if not all of the outstanding Medicare balances. You are responsible for all liability as laid out in your secondary health care plan.
- ***Medical Records*** We will be happy to copy your records for you. If you need copies, you must sign a medical records release form which we can mail to you for your signature. We do not charge patients for copies of their own records. We charge a fee for records requested by a third party (business, lawyers, etc)

I hereby assign all medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Spectrum Rehabilitation. I authorize the release of any relevant medical information that maybe requested of Peak Medical Management (billing service) in order to process this claim. I authorize payment of medical benefits to Spectrum Rehabilitation and Peak Medical Management (c/o Spectrum Rehabilitation). I am aware that if my insurance does not cover these services I will be responsible for charges.

I UNDERSTAND AND AGREE TO COMPLY WITH THE FINANCIAL POLICY EXPLAINED ABOVE

Signature:____

Date:________________________

Witness:____

Date:________________________