BodyIntel Financial Sheet

POLICIES: Financial, Appointment Cancellations/Fees, and Consent to Treat

Patient Name: _____Clinic Name: BodyIntel, LLC

Thank you for choosing BodyIntel for your health needs. We are truly committed to your treatment leading to a successful recovery. Please understand that payment of your bill is considered part of your treatment. This is a financial responsibility on your part that obligates you to ensure full payment of your bill. All patients must complete our information and insurance form before they see a therapist.

Regarding Your Insurance---IMPORTANT!

You are responsible for payment of any deductible, co-payments and co-insurances as determined by your contract with your insurance company. All co-pays and co-insurances are due at the time of treatment. In the event that your insurance changes to a plan where we are not participating providers, refer to the above paragraph. It is your responsibility to ensure that we are notified of any changes in your insurance coverage. It is your responsibility to know your benefits. Health insurance is not accepted for motor vehicle claims, workers compensation claims or personal injury claims with a 3rd party liability. **All patients covered under a motor vehicle claim must pay for their treatments if BodyIntel is not reimbursed within 3 months.** Referrals and treatment authorizations are ultimately the responsibility of the patient. Any visits that are performed and not covered by your insurance company because you have not obtained authorization, have not presented a valid referral, or have attended therapy beyond your benefit period, become solely your financial responsibility. If you receive a payment from the insurance company for services rendered by BodyIntel you must reimburse BodyIntel at the time of receipt of such payment. **If you have a secondary insurance you must present it at your initial visit.** We will not retroactively bill a secondary insurance if you fail to provide all the necessary insurance information. That balance will then become yours and you will have the responsibility of submitting the claim to your secondary insurance company. The patient agrees that if he/she defaults on any balance owed to BodyIntel and it becomes necessary for BodyIntel to engage the services of an attorney, collection agency or other lawful method of collection, the patient will pay the original balance owed, in addition to reimbursing BodyIntel 33 1/3% of the entire balance for legal fees, interest of 12% on the entire balance, plus court costs incurred in the collection of said debt.

In-Network Participating Provider/ Out-of-Network Provider/ Non-Capitated Provider

Regarding Insurance Billing:

As stated earlier, we bill your insurance carrier on your behalf as a courtesy to you. We will bill your insurance carrier up to two times to ensure payment of your benefit for services rendered by BodyIntel. However, in the event that billing of your insurance carrier does not satisfy your balance for services rendered, we will have no choice but to look to you for full settlement of your account. Please ensure that you have submitted the appropriate insurance.

Estimated Financial Responsibility:

Insurance plans, fee schedules and reimbursement rates frequently change. Every effort is made to stay current with these changes. Based on our current knowledge of your insurance plan, we have estimated your personal per-visit contribution for services rendered by BodyIntel. BodyIntel charges are usual, customary, and reasonable for this geographic region. These charges are established based on current-year data supplied by Medicode Corporation and Medical Data Research, Inc., (MDR), two independent firms who conduct geographical fee surveys. Our charges are in-line with the industry averages for physical therapy services in this geographical area.

Your estimated financial contribution per visit, after your health insurance carrier has made payment is: $ _____. (X_____(BodyIntel, Staff Initials)

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This is only an estimate based on historical co-payments/co-insurances with your health insurance carrier. In the event that your insurance carrier does not pay your claim and we have exhausted all means with your insurance carrier, we will set up a patient payment arrangement with you. You may wish to contact our office for a more detailed explanation and for payment options that are available. The estimated financial responsibility quote above does not include any additional amounts that may be owed to satisfy your deductible, if any. Refunds for any amount less than $5.00 will not be given unless requested in writing by the patient.

I have read the Financial Policy. I understand and agree to this Financial Policy& I acknowledge receipt of this document.

X_____ Date_____

Signature of Patient/Responsible Party

Missed Appointments and Late Charges:

Please, if you cannot attend your scheduled appointment, call to cancel it within 24 hours and reschedule it as soon as possible. We do make exceptions for true emergencies, but please call in as early as possible. All appointments that are missed without being cancelled within 24 hours are billed to you, not your insurance carrier. Our standard charge for missed appointments, without being cancelled by you, is $35.00 for the first offense and the full price of your session subsequently. On your invoice you will see this as a "NO SHOW" charge. A $15.00 late fee will be assessed on all unpaid balances.

I have read the Cancellation Policy and I understand that a cancellation must be made 24 hours in advance of my scheduled appointment to avoid being charged a cancellation fee. I also understand that a $15.00 late fee will be assessed on all unpaid balances.

X_____ Date_____

Signature of Patient/Responsible Party

Expiration of Physical Therapy, Pilates and Massage Packages:

All service packages will expire three months after the date of purchase. Gift certificateswill expire within 6 months from the date of purchase.

X_____ Date_____

Signature of Patient/Responsible Party

Consent to Treat and Authorization to Release Information, and Assignment of Benefits:

I hereby authorize BodyIntel through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. I further authorize BodyIntel to furnish the appropriate agencies, for the purpose of billing, any information acquired during the course of my treatment. I am assigning my physical therapy benefits to BodyIntel for the services in which I receive and authorize my insurance carrier to make payments to BodyIntel on my behalf. All records released require an administrative and copying fee paid to BodyIntel before they are released, regardless of the requestor. The adult accompanying a minor and the parents (guardians) are responsible for full payment. BodyIntel is HIPPA compliant with regard to information sharing policies.

X_____ Date_____

Signature of Patient/Responsible Party