Rehabilitation Associates of Naples

Comprehensive Rehabilitation services...to help meet life's challenges

Financial Policy Acknowledgement

PATIENT's NAME: _____
(First) (Middle) (Last)

The following sets forth our Financial Policy for office visits. *Please acknowledge your acceptance of the terms of this agreement by **initialing each of the lines** provided below and signing at the bottom.*

_____**PATIENT INFORMATION**: The patient agrees to provide accurate insurance and billing information prior to the first visit and notify us of any changes in insurance prior to subsequent visits.

_____**PAYMENT IN FULL IS REQUIRED AT THE TIME OF SERVICE**. Payment is due in full at the time of service, unless you are covered by Medicare or an insurance plan with which we are a participating provider. If you are covered by Medicare or an insurance plan with which we are a participating provider, all co-payments, deductibles and payment for non-covered services are due at the time of service. In some instances, we may not receive information from your plan regarding you co-pay until after the visit. However, once we have received confirmed of your co-pay, payment is expected at the time of service. A $25 service fee will be assessed for any returned check.

_____ **CANCELLATION POLICY**. Your health is important to us and keeping scheduled appointments is an important part of your maintaining your health. As a courtesy to other patients, please notify the office if you are unable to keep a scheduled appointment at least 24 hours prior to your scheduled appointment in order to allow us to find another patient to fill this appointment slot. We reserve the right to discharge a patient from the practice for failure to comply with an established plan of care of which scheduled appointments are an integral part.

_____ **INSURANCE:** Your insurance policy is a contract between you and your carrier. We are not a party to that contract. It is your responsibility to understand the terms of your insurance plan, covered services, co-pays and deductibles. Pre-certifications for procedures or testing are your responsibility. Please notify us in advance if your insurance company requires these. By signing this agreement, you agree to allow this office to file your insurance claim on your behalf and authorize payment directly to the physician. Any charges that are not paid by your insurance company within 45 days are your responsibility.

_____ **COLLECTIONS:** If payment is not received from either you or your insurance company within 90 days from the date of service(s), your account will be considered delinquent and subject to referral to an outside collection agency. All fees and costs associated with collections on your account will be added to your balance.

If you have any questions regarding our Financial Policy, please feel free to discuss it with a member of our office staff prior to your visit. The undersigned certifies that he/she has read the foregoing; and is duly authorized to execute the above and accept the terms.

_____ _____
Signature of Patient/Responsible Party Date

_____ _____
Relationship to Patient Witness