

VASTA PHYSICAL THERAPY Inc.

Thank you for choosing VASTA Physical Therapy, Inc. as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

Assignment of Benefits: I hereby assign and convey directly to VASTA Physical Therapy, Inc. all health plan benefits and/or insurance reimbursement benefits (including MedPay and/or Personal Injury Protection benefits), if any, otherwise payable to me for medical services, treatments, therapies and/or examinations rendered or provided by Provider regardless of its managed care network participation status. I also understand that I may revoke this assignment at any time by sending written notice to the Provider and my health plan. I hereby authorize Provider to release all medical information necessary to process my claims to the responsible Payor. I agree that if any payments are sent to me despite my assignment of benefits to Provider, I will promptly forward the funds and explanation of benefits/payment to Provider.

Financial Responsibility: You understand that insurance billing is a service which may be provided as a courtesy and you agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.

Payment is expected within thirty (30) days of your claims being submitted unless we are in-network with or agree to accept assignment from your health plan or other responsible payor and you check the assignment box on the following page or you have made other payment arrangements with us.

Policy:

- **In-Network Policy.** If we are in-network with your health plan, we will submit the claims to your health plan on your behalf and your health plan will send payment directly to us. If your health plan denies payment of our claims, in whole or in part, you are responsible for paying any and all unpaid amounts within thirty (30) days of receiving our statement (subject to our appeals policy below) unless you have made other payment arrangements with us.
- **Out-of-Network Policy** for Physical Therapy Services. (Commercial Health Plans – does not apply to Medicare) If you are receiving physical therapy services and we are out-of-network with your health plan and you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services. On a case-by-case basis, we may, at our sole discretion, agree to accept assignment from your health plan. This means we will bill your health plan for our services directly and await payment from your health plan. If we accept assignment, you agree that if your health plan does not honor the assignment and sends payment to you, you will promptly forward the payments to us. You further agree that if your health plan denies payment of our claims, in whole or in part, you are responsible for paying any and all unpaid amounts within thirty (30) days of receiving our statement unless we agree to await payment pending the outcome of an appeal.

- Medicare Policy (for Medicare Part B). If you are a Medicare beneficiary, you understand that our licensed physical therapists are not enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide. Since we are not enrolled providers, we cannot submit claims to Medicare and Medicare will not pay for our services even though the same services might be paid by Medicare if you obtained them from a Medicare enrolled provider. Therefore, by choosing our services, you are exercising your right to privacy and electing, of your own free will, not to use your Medicare benefits. As such, you are agreeing to pay cash at the time of service for all services you elect to receive from us with no expectation that Medicare or your Medicare Supplemental Insurance Plan will reimburse you. You understand that we will not submit claims to Medicare on your behalf or provide you with a statement or billing codes that you can submit to Medicare yourself. If you want Medicare to pay for services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. If you decide at any point after you start services with us that you want Medicare to pay for the services it covers, we will be happy to recommend a Medicare enrolled provider and terminate your services with us. You also understand that since we are not enrolled Medicare providers, our services are not subject to Medicare's maximum allowable charge. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.

 - Medicare as a Secondary Payer. If you have a commercial insurance plan, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. However, since we are not Medicare enrolled providers, Medicare will not pay your copays, co-insurance or deductibles as a secondary payer. You understand and agree to carry out whatever procedures are necessary to prevent your commercial insurer from automatically forwarding our bills to Medicare.
 - Medicare Advantage Plans ("MAP"). We are not in-network with any Medicare Advantage Plans. If your MAP offers out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your MAP for reimbursement for the services your health plan covers. You are responsible for contacting your MAP to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your MAP denies, in whole or in part, your claims for our services.

- Pre-Paid Packages. If you purchase a discount package of services, the package discount is applied to the last visit in the package. You must use your visits within 1 year. If you don't use your visits within that time frame or you request a refund for the unused visits, we will refund the excess amount paid, if any, after applying the package discount to the last visit and our regular cash payment fee to all other unused visits.

 - Use of Health Savings Accounts (HSA). If you purchase a pre-paid package plan through your HSA account we will give you a receipt for the pre-paid services that you can, at your discretion and in accordance with your HSA plan rules, submit for reimbursement. If you request a refund for unused services that you paid for through your HSA, we will make the refund directly to your HSA account. If your HSA requires you to actually receive the services before submitting claims for reimbursement, we will provide you with a receipt for services actually received to date upon request. You are responsible for complying with HSA rules when determining whether the services you purchase from us can be paid from an HSA account.
 - Use of Health Reimbursement Arrangement (HRA) or Flexible Spending Account (FSA). An HRA and FSA will only reimburse for actual services received (not pre-paid services). Therefore, if you purchase a discounted pre-paid package plan and want your HRA or FSA to reimburse you, we will provide you with a receipt that you can submit for reimbursement after you have used your entire package. Upon request, we will also provide a receipt for visits used to date that you

can, at your discretion and in accordance with your HRA or FSA rules, submit for reimbursement. Please note that HRA and FSA plans have rules about what services qualify for reimbursement. You are responsible for complying with your HRA and/or FSA plan rules when determining whether the services you purchase from qualify for reimbursement.

- No-fault, Auto and Other Liability Policy. If a no-fault, auto or other liability insurance policy will be responsible for paying your claims, we may, at our discretion, wait for payment when your case settles. If we do, you agree to pay the late payment interest fees as stated below. You hereby authorize and direct your attorney, adjustor and/or insurance company involved in your case to pay directly to VASTA Physical Therapy, Inc. all sums due and owing for the services you received plus any late payment interest due from any settlement, judgment or verdict rendered in your case. This means you hereby assign and grant a lien to VASTA Physical Therapy, Inc. in any amount sufficient to pay any outstanding balance owed to VASTA Physical Therapy, Inc. and authorize/require your attorney and/or responsible insurance Payor to recognize and comply with this assignment and lien. You further understand that we are not obligated to discount any portion of our service or interest fees when your case settles regardless of the amount of your settlement, judgment or verdict or whether your settlement, judgment or verdict adequately covers your balance due to us.
- Workers' Compensation Policy. If your injury is work related, we will bill the workers' compensation carrier if you have filed an injury report. If you have not filed an injury report, your injury is later determined not to be work related or any of the treatment you receive is denied, you will be responsible for paying our claims. Therefore, you agree to notify us immediately if you receive notice of any controversy from your employer or the workers' compensation insurance carrier.
- Privacy Rights. You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. By paying for your services at the time of service, we assume you are exercising this right to privacy we will not disclose your medical records to any third party, including your health insurance carrier or Medicare, unless we have agreed to accept assignment and await payment from your health insurance insurer. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Authorization to Release Protected Health Information form before we will disclose your health information.
- Appeals Policy. You are responsible for filing appeals if our claims are denied. We may, on a case by case basis, agree to serve as your Authorized Representative and file appeals on your behalf if you sign our Authorized Representative form. By appointing us as your Authorized Representative, we are given the right by you to (1) obtain information regarding the claim to the same extent as you; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit or workers' compensation plan, health care benefit plan, or plan administrator, including but not limited to claims of a breach of contract or fiduciary duty. Our acceptance of the appointment as your Authorized Representative is no guarantee that your claims will be paid or alter your ultimate responsibility to pay our claims. If you have a Medicare Advantage Plan, we will not act as your Authorized Representative.

- Late Payment Interest. Unless prohibited by applicable law, interest in the amount of 4.9% per year (added monthly) may be added to your bill for any and all claims that are not paid within ninety (90) days of the invoice or statement date. You agree to be personally responsible for paying such interest unless the responsible Payor is required to pay such interest under federal, state or other applicable laws.
- Collection Policy. You understand that we are not required to obtain your written authorization to disclose protected health information to a collection agency or court of law that may be necessary to collect payment for services rendered. Should collection proceedings or other legal action become necessary to collect an overdue account, you will be responsible for paying the collection costs plus court costs and filing fees incurred by the practice.

It is the general policy of VASTA Physical Therapy Inc. to collect *at time of service* for all co-pays, deductibles, and non-covered services.

If a payment is made by check that has insufficient funds, a 'returned check' fee of \$35 will be charged.

24 hours notice is required to cancel an appointment and avoid the 'no show' fee of \$45.

Name: _____ **Date:** _____

Signature: _____

Signing for (if applicable): _____

* write name of patient if signing as guarantor