SEACOAST
HAND THERAPY LLC

| | | |
|---|---|---|
| **Patient Legal Name** | | **Male / Female** **Married?** |
| **Mailing Address** | **City** | **State / Zip** |
| **Date of Birth** | **Social Security#** *(for billing purposes)* | |
| **Home Phone#** | **Work Phone#** | **Cell Phone#** |
| **Employer** | | |
| **Name of Referring Physician** | | **Primary Care Physician** |
| **Reason For Visit** | **Have you had therapy in the past year?** | **When** |

| | |
|---|---|
| Please provide your insurance cards for copy | **IF GAURANTOR IS **OTHER** THAN CARD STATES - please complete below |
| *GUARANTOR NAME* | *DATE OF BIRTH* |
| *PATIENT'S RELATIONSHIP TO GUARANTOR* | *[ ] SELF [ ] SPOUSE [ ] CHILD* |

**IS THIS A WORKER'S COMPENSATION CLAIM? or an AUTO INSURANCE CLAIM?**

| | |
|---|---|
| **YES NO DATE OF INJURY** | **YES NO DATE OF ACCIDENT** |
| **WORKERS COMP INSURANCE COMPANY** | **AUTO INSURANCE COMPANY NAME** |
| **CLAIM #** **ADJUSTER** | **PHONE #** |

***I authorize the release of any medical information necessary to process my disability and/or medical claim. I authorize payment of medical benefits to Seacoast Hand Therapy, LLC for services rendered. I understand that I am fully liable for any services not paid for on my behalf. I have read and completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested.***

**As of today _____ Are you receiving any "HOME HEALTH CARE/SERVICES" ? ____YES _____NO**

_____ _____

***Signature: Patient, Guardian, or Personal Representative*** ***Date***

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# CONSENT FORM

For Use and Disclosure of **P**rotected **H**ealth **I**nformation *(PHI)*
as well as for **T**reatment, **P**ayment, or Healthcare **O**perations *(TPO)*

I understand that as part of my healthcare, *Seacoast Hand Therapy, LLC* originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care. I also understand this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

With this consent, *Seacoast Hand Therapy, LLC* may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO (treatment, payment, & operations), such as appointment reminders, insurance items and any information pertaining to my clinical care.

With this consent, *Seacoast Hand Therapy, LLC* may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders, account statements, and other correspondence.

*Seacoast Hand Therapy, LLC* may e-mail correspondence to me related to my healthcare provided at this facility. I have the right to request that *Seacoast Hand Therapy, LLC* restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I understand that I have the right to restrict my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that *Seacoast Hand Therapy, LLC* is not required to agree to the restrictions requested.

I may revoke my consent in writing except to the extent that *Seacoast Hand Therapy, LLC* has already made disclosures in reliance upon my prior consent.

By signing this form, I am consenting to *Seacoast Hand Therapy LLC* to use and disclose my PHI to carry out my TPO. We encourage you to read the *Notice of Privacy Practices* that is available to you at the front desk prior to signing this consent.

**If I do not sign this consent, Seacoast Hand Therapy, LLC may decline to provide treatment to me.**

Print Patient Name _____

Signature of Patient or Legal Guardian _____

Date: _____

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## PAYMENT POLICY & PROCEDURES

- **COPAYS & DEDUCTIBLES:** Please be prepared to pay your copay and any deductibles due at each visit. If your plan has a deductible that has not been met prior to your therapy visits, payment in full for services rendered ***is due at time of visit***. We will provide an ***estimated $ amount due*** that will reflect the Seacoast Hand Therapy contracted rate with your individual insurer. *Seacoast Hand Therapy makes every effort to verify patients' insurance eligibility and benefits prior to first visit/evaluation. This service is not a guarantee of benefits, however, we hope it will be helpful and provide awareness of the therapy benefits available to patient.*

- **OUT OF POCKET EXPENSE:** These expenses may include various customizable splints, exercise putty, theraband, digi sleeves, exercise equipment, and topical creams, ionto patches, etc. Your treating therapist may recommend one or more of these splint and/or miscellaneous supplies depending on your treatment plan. ***Payment in full for these items will be expected at time of service***. Please discuss any questions and/or concerns you may have regarding splints and supplies needed for your individual *Plan of Care* with your treating therapist.

- **LITIGATION CASES……..**
  **CONTROVERTED WORKERS COMP CASES……..**
  **MOTOR VEHICLE ACCIDENT CASES……..**
  **TERMINATED INSURANCE POLICY ……..**
  In cases involving Litigation, Controverted Workers Comp, Terminated Insurance Policies, and/or Motor Vehicle Accidents, the patient is responsible for payment of all fees at the time of service. If the case/claim is controverted after treatment has been received, it is the patient's responsibility to supply an alternative insurance or other form of payment that will cover the services rendered by Seacoast Hand Therapy.

- **PAST DUE ACCOUNT BALANCES**: Account balances unpaid after 60 days will be subject to a late fee of 18% per year or 1-1/2 % per month on the unpaid balance. **Any accounts with a past due balance beyond 3 months from date of service are at risk of being sent to a collection agency.** Delinquent accounts will be assessed any and all additional costs which may arise as a result of collection proceedings. Seacoast Hand Therapy is a small, private, and unique practice. We take pride in offering such personalized care in good faith; therefore, a timely reimbursement is anticipated so as to meet our expenditures as well.

- **INSUFICIENT FUNDS:** **A $35.00 Fee** will be charged for any "returned check" as well as any bank fee that is incurred.

- **CANCELLATION NOTICE**: Please call **at least 24 hours in advance** when you know that you will not be able to keep an appointment. Since we provide such personal "one on one" service to our patients, NO-SHOW and CANCELLED appointments impact us significantly. ***There will be a $75.00 charge for appointments missed (no show) or those changed on short notice (less than 24 hrs.)*** of your appointment. This charge will be considered "self-pay". Insurances will not cover this fee.

- **PARTICIPATING PROVIDER:** Seacoast Hand Therapy is a participating provider with many medical insurance companies. Due to the evolving medical world, each individual plan has multiple facets to their coverage, therefore making it imperative that each patient become knowledgeable regarding the covered and non-covered benefits available to them. The patient/guarantor is responsible for all insurance information, which includes obtaining initial authorization if necessary, and the terms and liabilities of their individual health coverage. If for any reason these services are not covered by the health insurer and the information that has been provided, the **patient/guarantor is fully liable for any unpaid services and/or supplies.**

- **NON – PARTICIPATING PROVIDER:** If Seacoast Hand Therapy is ***not*** a participating provider with your medical insurance company, ***payment is expected in full*** at the time of service. You will be responsible for the full amount regardless of the amount deemed usual and customary by these non-preferred insurance carriers.

## MEDICARE B – insured patients

## CIGNA – insured patients

- Seacoast Hand Therapy ***IS a participating provider for Physical & Occupational Therapy treatments*** with MEDICARE B and CIGNA.

However……

- Seacoast Hand Therapy is NOT a participating provider with MEDICARE B and CIGNA for DME **(Durable Medical Equipment)**, ***which includes custom orthosis, prefabricated splints, and supplies***. Therefore, any secondary insurance or companion plan will not cover these items as well.

- Please discuss with your treating therapist any questions and/or concerns you may have regarding durable medical equipment which includes splints and supplies **that may be needed for your individual treatment plan.**

- HOME HEALTH CARE / SERVICES: If you are currently receiving home health care services for any diagnosis, your therapy expenses at Seacoast Hand Therapy will NOT be covered by Medicare B and may not be covered by other insurers – please notify the front desk personnel for clarification. If you are enrolled to receive Home Health Care Services at this time, any and all expenses incurred at Seacoast Hand Therapy will be considered an out of pocket expense/ PATIENT RESPONSIBILITY and due at time of visit.

**I have read, understood, and agree to the terms of the Seacoast Hand Therapy Payment Policy.**

_____ _____

*Signature: Patient, Guardian, or Personal Representative* Date