Inspirit Therapy Associates
Feel better physically. Feel better for life.
3852 Creamery Rd DePere WI 54115
Ph: (920) 338-9670 Fax: (920) 338-9680

FINANCIAL POLICY STATEMENT, INSURANCE RELEASE & PRIVACY NOTICE

Dear Patient/ Responsible Party: Thank you for choosing Inspirit Therapy Associates. To ensure that you are familiar with our financial policies, we have prepared this explanation for your review.

Financial Policy:

1. **It is your responsibility to know and understand your individual policy guidelines, limitations, and exclusions.** We will bill your insurance carrier as a courtesy to you. However, the verification of benefits in not a guarantee that your insurance company will provide 100% coverage, and you are responsible for copayments, coinsurance, deductibles, and non-covered charges at the time of service. Your insurance benefits as quoted to us by your insurance carrier will be reviewed with you. We assume no liability for any errors quoted to us by your insurance carrier.
2. If insurance coverage or other program benefits are not available, you are responsible for all charges at the time service is rendered. Payment plans can be established with our Financial Advisor if needed.
3. If you claim Worker's Compensation benefits or Motor Vehicle Insurance benefits, and are subsequently denied such benefits, you will be held responsible for the total amount of charges for services rendered to you.
4. We accept payment by cash, check, MasterCard, Visa, or money order. If a check is returned for non-sufficient funds, you will be assessed a $40 returned check charge and checks will no longer be accepted as a form of payment.
5. Nonpayment on an account balance will result in small claims actions if all attempts made by our office to collect have failed. If smalls claims are filed, all additional costs incurred become the responsibility of the patient/responsible party.

No show/ cancellation policy:

1. If you cannot make a schedule appointment for any reason, please contact us at 920-338-9670 as early as you can, but no later than 2 hours prior to your appointment.
2. Repeated no-shows without notice or cancellation can be subject to being discharged from services and may be subject to a $25.00 no show fee.

Refusal/ Discharge from Services:

The following may result in client discharge where client is no longer allowed to receive services.

- Failure to comply with office policies.
- Missing 4 therapy sessions without prior notice, or being absent from 30% of scheduled therapy sessions over a one-month period (this includes cancellations)
- Past-due account referred to small claims court. Past-due accounts may be charged an annual percentage rate.

Assignment of Insurance Benefits & Release

I understand that I am financially responsible for all charges whether paid by insurance. I authorize Andrews Physical Therapy Dba Inspirit Therapy Associates to disclose my health care and treatment information to Medicare or other insurance company and its agents for the purpose of determining benefits and obtaining payment for related services. I hereby assign all payments for services rendered to Andrews Physical Therapy.

I have read and understand the above policies of Andrews Physical Therapy Dba Inspirit Therapy Associates.

Patient's Name: _____

(MINOR)Responsible Party's Name: _____Relationship: _____

Patient/Responsible Party Signature: _____Date:_____

CONTINUE ON BACK

PATIENT RECORD DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communications of PHI be made by alternative means, such as sending information to the individual's office rather than to their home. These provisions do not apply to the use or disclosure made pursuant to an authorization by the individual**. If medical records need to be sent to or obtained from another provider a separate medical records release must be signed. Inspirit Therapy Associates will never release any PHI without obtaining written consent of the patient.**

I wish to be contacted by (Check all that apply):

☐ Phone Home: _____ Work: _____ Cell: _____

☐ E-mail: _____

IDENTIFICATION OF COMMINICATION DISCLOSURE FOR FAMILY MEMBERS/FRIENDS/CARE GIVERS:

I give permission for Inspirit Therapy to communicate with the following person(s) regarding my health information that is directly related to their involvement with my care or payment related to my care. These communications may occur when the identified person(s) join me at my clinic visit, or communicate for me by telephone, email, or other electronic method.

Name: _____ Relationship _____ Phone: _____

Name: _____ Relationship _____ Phone: _____

Name: _____ Relationship _____ Phone: _____

I have received a copy of the HIPAA privacy policy.

Patient's Name: _____

(MINOR)Responsible Party's Name: _____Relationship: _____

Patient/Responsible Party Signature: _____Date: _____

Policy Effective 05/13/2021

Please see Reverse