Inspirit Therapy Associates
Feel Better for Life.

3852 Creamery Road De Pere WI, 54115
Phone: (920)338-9670 Fax: (920)338-9680

Financial Agreement Policy, Insurance Release, and Privacy Notice

Thank you for choosing Inspirit Therapy Associates to be your healthcare provider. We are committed to building a relationship with you and your family. It is important to have a professional relationship, by ensuring all our patients and their families clearly understand our Patient Financial Policy as well as the insurance release and privacy notice. It is the patient's responsibility to notify our office of any information changes, which includes address, name, or insurance information as soon as you receive the information.

Financial General Guidelines:

It is important you understand your individual policy guidelines, limitations, and exclusions. As a courtesy we bill your insurance provider, this is **NOT** a guarantee that services will be paid. You are responsible for co-payments and outstanding balances prior to service being provided. We can print a statement for any outstanding balances on your account at any time you request it. If you have a Worker's Compensation benefits or Motor Vehicle Insurance benefits and your claims are denied, you as the patient will be held responsible for all charges for services that are rendered to you. After three months of non-payment, you will be sent a final notification to set up payment or payment plan with our billing department, your account then will be sent to our Collections Agency. You will be held responsible for any fees associated with your account being sent to collections.

Co-Pays:

*By law we **MUST** collect your insurance carrier's designated co-pay at the time of service.* All co-payments and past due balance are due at the time of check in unless an arrangement has been made with the billing department. We accept cash, check, Mastercard, VISA, Discover and money orders. No post-dated checks will be accepted. There will be a **$40** fee added to your account for any returned check and we will no longer be able to accept a check as a form of payment.

Referrals:

It is the patient's responsibility to check with your health insurance plan to verify if a referral is required by your health insurance plan. Each health insurance plan has different requirements for referrals prior to starting Physical Therapy. ***Referrals are required prior*** to scheduling if you have either a Medicare or Medicaid plan. Our fax number is (920)338-9680, please have your physician's office fax the referral to our office. If your health insurance plan requires a referral, we must have received the referral via fax, or you must have the referral in hand the date of your initial evaluation. If you are unable to provide the referral the date and time of your appointment, you may be responsible for the service costs for the initial evaluation, depending on your insurance plan.

New Patient Paperwork:

Patients are required to have new patient paperwork completed **48 hours prior** to their first appointment. If the paperwork is not completed 48 hours prior to you first appointment, we reserve the right to reschedule your appointment. Please make sure to bring your insurance cards with you to your first appointment, we will make a photocopy of your insurance cards the date of your first appointment to file in your medical records.

No Show/Late Cancellation Policy:

Please call our office as soon as possible to cancel your appointment. ***If you are a no show for your scheduled appointment or cancel your appointment with less than 24 hours' notice, there is a $50 fee that must be paid prior to your next scheduled appointment.*** This applies to all self-pay services, except laser. With laser appointments the fee will be ***$40*** added to your account unless you have a package and then one session will be subtracted from your account. Repeated no show or late cancellations could result in being discharged for services. In a calendar year if there are two no-shows or three appointments with a late cancellation, we reserve the right to discontinue services, which is up to the discretion of the provider. We will send out a letter after the first no-show or two late cancellations, to let you know it is pertinent that there are no more late cancellations or no-shows for your scheduled appointments.

Self-Pay Services:

We do offer the option of paying cash for services instead of billing insurance. ***Payment is due at the time of service and insurance will not be billed.*** Please see policy on fee schedule for self-pay services.

Payment Plans:

We want to work with you, so you can receive the healthcare services you require. We do offer payment plans for individuals with higher balances or a plan of care that you may not be able to afford in the moment. Please speak to the billing department to discuss a payment plan.

I have read the financial policies listed above and the signature below serves as the acknowledgement of a clear understanding of my financial responsibility. I understand that I assume financial responsibility and will pay all charges in full if my insurance carrier denies coverage or payment for services that were provided.

Signature of Patient/Responsible Party: _____

Name of Patient/Responsible Party (Print): _____

Date: _____

Relationship to Patient: _____

Assignment of Insurance Benefits & Release:
I understand that I am financially responsible for all charges after insurance has processed the claim. 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 wish to be contacted by:

Phone: _____

Email: _____

HIPAA:

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 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 have received a copy of the HIPAA privacy policy.

Patient's Name: _____

Responsible Party's Name: _____ ***Relationship:*** _____

Patient/Responsible Party Signature: _____

Identification of Communication Disclosure for Family Members/Friends/Caregivers:

I give permission for Inspirit Therapy to communicate with the following person or persons 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 or persons join me at the office visit, or communicate for me by telephone, email, or other means.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____