Quality Rehab Care, LLC

Important Company Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully and indicate your agreement by signing the bottom of the next page.

24-Hour Notice Fee

If you wish to change or cancel an appointment, we require a minimum 24-hour notice. Anything less will result in a **$25** fee charged to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses. We don't charge you the actual cost for that appointment but rather a mere **$25** fee. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

Coinsurance, Co-pay and/or Deductible are due upon arrival

Your coinsurance, co-pay and/or deductible will be paid at the time of service. Any outstanding balance on your account will be collected as well. This arrangement is part of your contract with your insurance company. Failure on our part to collect payment from patients can be considered fraud. Please help us in upholding the law by paying your co-payments at each visit. If you happen to forget your wallet or checkbook, we may still be able to see you upon completion of a "*Promise-to-Pay Form*", this form carries a minimal fee that allows you to keep your appointment.

No-Shows

If you fail to show for an appointment without notice, all future appointments will be removed and a $25 fee assessed to your account. You may re-schedule appointments again on a "first come, first serve basis".

Cell phones must be shut OFF or silent.

We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off. Thank you.

Children requiring supervision are NOT allowed to attend sessions with you.

We do not offer childcare, if your child does not require supervision and can wait for you quietly then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.

Financial Responsibility

As a courtesy to you and your insurance company, it is our office policy to file your claim with your insurance. We will make one attempt to correct any claims that are denied, and we will refile the claim for you. If the claim is denied a second time, the claim will be placed to the patient responsibility and payment will be collected from the patient. You will be given an itemized receipt and you may submit it to your insurance company for reimbursement.

Our office will make every effort to verify your insurance coverage in an effort to help you determine exactly what physical therapy coverages are available to you under your policy. Please take the time to contact your insurance company as well as to verify and understand the coverage provided to you by your insurance company.

Our office cannot promise that an insurance company will pay for the usual and customary charges of this office. Nor will this office enter any dispute with an insurance company over reimbursement or the amount of reimbursement. Since we do not own your insurance policy and since from time to time,

we experience difficulty in collecting from insurance companies, if your insurance company does not respond to a request for payment within 60 days, the balance will become your responsibility.

I understand that I am responsible for the payment of this account and hereby assume and guarantee prompt payment for all expenses incurred. I understand that as courtesy, Quality Rehab Care, LLC will directly bill my insurance company and that I am ultimately responsible for payment of my account.

Collections and Attorney fees

I also understand that if my account is sent to collections for payment the fees charged by the collection agency will be added to my total balance. Also, any unpaid debts will accrue interest at the highest rate allowed by law. If patient fails to make payment when services are rendered, a late fee of ten percent (10%) will be charged. In addition, such payment shall bear interest at the rate of eighteen percent (18%) per annum from the date such payment became due to the date of payment thereof by patient. Patient shall be responsible for attorney's fees.

Financial Hardship

If you are experiencing financial difficulties and are unable to afford the cost of our services, we have a "Financial Hardship Form" which may be filled-out. If you qualify for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portions of the bill. Ask the front desk person for assistance.

Important Notice from the Federal Government:

"It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments . . . even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's - Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231 (h) of HIPAA]. Exceptional cases do apply. Please see contact info for more information, Office of Inspector General, Department of Health and Human Services.
Contact by phone: 202 619-1343, by fax: 202 260-8512, by email: paffairs@oig.hhs.gov.

I acknowledge that I have read and understand all the above information and agree to abide by the office policies described above.
If patient is a minor, I the parent/legal guardian, give full permission and consent for the treatment as deemed necessary or advisable.

PATIENT:

_____
(Signature)

_____
(Print Name and Todays' Date)

We look forward to building a successful relationship with you that lasts a lifetime!