



LARSON REHABILITATION
SERVICES, PLC

O P T
E T S

Billing, Privacy and Informed Consent

Appointment Cancellations

As a courtesy to our office and our patients, please notify our office as soon as possible your need to reschedule or cancel an appointment. We ask that you let our office know so that we may make the appropriate arrangements to best serve all those who seek our services. If repeated absences occur, it may be necessary to assess a \$25.00 fee for the negative impact on patient care. This charge is not billable to an insurance company and will be your responsibility.

Billing Policy, Release, and Authorization for Assignment of Benefits

I authorize Larson Rehabilitation Services, PLC to bill my insurance company directly for the covered portion of charges, and I authorize payment of medical benefits directly to Larson Rehabilitation Services, PLC.

I authorize Larson Rehabilitation Services, PLC to release medical or other information necessary to process the claims for services rendered during treatment. I understand that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on rehabilitation treatments. I understand that I am responsible for knowing and meeting the requirements of my particular insurance plan. I understand that I am ultimately responsible for my rehabilitation charges, and I agree to pay my deductible, my co-insurance, co-payments, and any other charges not reimbursed by my insurance company. Co-payments and self pay fees are due at time of service. Checks returned due to insufficient funds are subject to a \$25.00 charge. In addition, if you are involved in litigation or payment dispute for personal injury which may delay payment, interest of 10% will be applied monthly to the outstanding balance beginning 30 days after the start of treatment.

Collection Policy

I understand that unpaid balances consisting of co-payment, co-insurance, deductible amounts and any other amounts not covered by my insurance company are my responsibility and must be paid, or payment arranged, within 90 days of statement. Unless payment arrangements are in effect, all final account balances 90 days and older will be referred to a collection agency. The administrative fees associated with the collection process will be added to the patient balance.

Privacy Policies

I certify that I have received a copy of the Privacy Practices for Larson Rehabilitation Services, PLC.

Informed Consent

I have the right to understand the rehabilitation plan. The purpose of each treatment device including risks and benefits will be explained to me. I also have the right to decline treatment at any time.

I HAVE READ AND UNDERSTAND THE INFORMATION OUTLINED ABOVE.

Signature: _____ Date: _____

E S A , A