FINANCIAL POLICY

Payments Required At The Time Of Service – Co-pays, as indicated by your insurance carrier, must be paid at the time of service. If you are unable to pay your co-pay at the time of service, you may be asked to reschedule your appointment. If your deductible has not been met, we request that you make a payment at each visit to help satisfy your deductible in an effort to ease the burden of receiving a large bill at the end of your treatment. If you are a Non-Insurance/Self-Pay Patient, payment for all services must be paid at the time of service. **We accept Cash, Check, Debit/Credit/HSA/Flex (Visa, Mastercard and Discover) as forms of payment.** ***We will charge a $25.00 fee for returned checks.***

Billing Process – Our billing service, MeCMARA, LLC (Medical Claims Management and Reimbursement Affiliates) will submit claims to your insurance company. Payment and adjustment information received by your insurance company will be applied to your account. You will receive monthly statements indicating the remaining balance of any co-insurance amounts, deductibles or non-covered charges as indicated by your insurance company. The balance is due and payable when the statement is received, and is considered past due if not paid within 30 days. If you are unable to pay the balance in full, you must contact our billing service at 815-674-2386 to set up a Payment Plan. Each insurance payment will be audited for accuracy and any disputes involving incorrect payments and/or denials will be rebilled to your insurance company. In the even that we are unable to resolve disputes with your insurance company, you will be held responsible for the full payment.

Past Due Accounts – A statement charge in the amount of $2.50 per month will be applied to an account balance that has not been paid within thirty (30) days of receipt of a statement. If your account becomes past due, we may need to take necessary steps to collect this debt. If we refer your account to a collection agency, you agree to pay all collection costs associated with this service. If your account is referred to attorney, you agree to pay all attorney fees plus all court costs incurred in an effort to collect this debt. You understand and agree that if your account is referred for collections, the fact that you have received treatment at our office may become a matter of public record.

Reviewing Your Insurance Benefits – We recommend that you call your insurance carrier directly with any specific questions you may have regarding physical therapy benefits. Your insurance policy is a contract between you and your insurance company and it is your responsibility to be aware of your policy coverage relating to physical therapy, deductible, co-pay, coinsurance, visit limitations, effective dates of coverage, referral requirements and pre-authorization requirements. As a courtesy, we will call your insurance carrier prior to your visit to verify coverage, referral requirements and pre-authorization requirements, but we cannot guarantee the accuracy of the information provided to us by your insurance company. You will be contacted by our billing service only if an issue with your coverage has been discovered.

In-Network vs Out-Of-Network Benefits – If we are an In-Network Provider with your insurance company, we agree to accept the allowable amount (usual and customary) established by your insurance company. Although we may be able to estimate what your insurance company will pay and the patient's responsibility, it is the insurance company that will make the final determination of payment and coverage. Please verify with your insurance company whether we are an In-Network or an Out-Of-Network Provider. If we are Out-Of-Network with your insurance company, we are not required to write-off any balances that are considered over the usual and customary amount. You agree to pay any portion not paid by your insurance company.

Insurance Information – It is the responsibility of the patient to provide Integrated Orthopedic Physical Therapy, LLC with accurate billing information including but not limited to the name and address of the insurance company, policy and group numbers, responsible party, type of accident (worker's compensation, auto or other accident) and date of injury. Should any of this information change, it is your responsibility to provide updated information in a timely manner. If you neglect to supply our office with the updated information in a timely manner, you will be entirely responsible for the account balance if the insurance company cannot be billed within the timely filing requirements per our contact.

Referrals/Prior Authorizations – If your insurance company requires a referral from your primary care physician, you are responsible for making sure the referral has been made prior to receiving service. Please contact your primary care physician prior to your appointment to confirm. Failure to do so may result in benefits paid at a lower rate. You will be responsible for payment of services provided without a referral. We will call your insurance company to obtain any prior authorizations necessary.

Worker's Compensation Claims – If your services are related to a worker's compensation claim, you must provide us with the necessary information to file your claim including the name of the worker's compensation carrier, the claim number, date of injury and the contact information of your case worker/adjuster. We also require that a copy of your medical insurance card to be placed in your file in the event that your worker's compensation claim is denied and we need to bill your medical insurance for services.

MVA – Motor Vehicle Claims – We will bill Personal Injury Protection (PIP) auto insurance claims through your motor vehicle insurance as the primary insurance and will bill your private medical insurance when your PIP benefits have been exhausted. In absence of medical insurance, other financial arrangements must be made with our billing service. Payment for services related to a Motor Vehicle Claim remains the patient's responsibility.

Minors – A parent or legal guardian must accompany the minor patient at the time of the initial visit. The guardian is responsible for full payment as outlined in the above financial policy. The parent or legal guardian accompanying the minor patient will have full responsibility for payment should any dispute arise.

Supplies and Non-Covered Services – In the even that we recommend a supply or service that is typically not covered by your insurance, you will have the decision to receive the supply(s) or service. These supplies or services must be paid for at the time of service. Used supplies or open packages used for healthcare are non-returnable and will not be refunded.

Missed Appointments:
We appreciate your time and request that you arrive at your appointment on time. You will be billed for missed appointments if you give less than a 24-hour notice of cancellation. Please call in advance if you need to reschedule your appointment. If you have cancelled or not shown up 2 times we reserve the right to discontinue future therapy appointments. We appreciate your cooperation.

IN SUMMARY – You are responsible for knowing your insurance policy benefits and requirements. We will bill your insurance carrier for services provided and you agree to allow your insurance company to make payment directly to Integrated Orthopedic Physical Therapy, LLC. You are responsible for co-pays, deductibles, and co-insurance according to your insurance policy. We will work with you and your insurance company to resolve disputes but cannot guarantee that all services will be covered. Payment for non-covered items and services are due at the time of service. If you need further clarification, please ask your therapist or call our billing service at 815-674-2386.

I understand and agree to the terms of this Financial Policy. I authorize Integrated Orthopedic Physical Therapy, LLC to bill my insurer(s) for all services provided and I authorize my insurer(s) to make payment directly to Integrated Orthopedic Physical Therapy, LLC for such services.

Integrated Orthopedic Physical Therapy, LLC

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. This form is a "friendly" version. A more complete text is available upon request.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

This acknowledgment which allows the practice to use and or disclose personality identifiable health information for treatment, Payment or health care operations, is made pursuant to the requirements of 45 CFR 164.520 © (2)(ii), part of the federal privacy regulations for the health insurance privacy and accountability act of 1996.

The following policies are adopted by IOPT:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in secure file racks and will not contain any coding which identifies a patient's condition or information, which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents, which may include PHI by government agencies or insurance payers in normal performance of their duties.

Integrated Orthopedic Physical Therapy,LLC

HIPAA Information and Consent Form

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the therapist/owners.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.
10. I give staff and medical providers acting on behalf of **Integrated Orthopedic Physical Therapy, LLC** permission to leave messages on my email, answering machine or voicemail regarding appointment times, treatment and the account/Insurance information.

Financial Policy

I understand and agree to the terms of this Financial Policy. I authorize Integrated Orthopedic Physical Therapy, LLC to bill my insurer(s) for all services provided and I authorize my insurer(s) to make payment directly to Integrated Orthopedic Physical Therapy, LLC for such services.

_____ _____

Patient Name Date

_____ _____

Patient (or Guardian) Signature Relationship to the Patient

HIPAA Information and Consent Form

I, _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature:_____ Date:_____

Witness:_____ Date:_____

I give staff and medical providers acting on behalf of **Integrated Orthopedic Physical Therapy, LLC** permission to discuss appointment times, treatment and account/information with the following persons.

Name:_____ Relationship:_____

Phone: (_____)_____-_____

Cancellation/No Show Policy:

Integrated Orthopedic PT, LLC (IOPT) understands that situations and circumstances may arise that you may need to cancel your scheduled appointment. We request a 24-hour advanced notice of cancellation or rescheduling.

We reserve the right to charge a $25.00 fee for each No Show or cancellation made without a 24- hour notice.

If you cancel or do NOT SHOW up for up to 2 times, IOPT reserves the right to discontinue further treatment appointments.

I have read and understand the above cancellation/No Show policy.

Patient Signature: _____

Date: _____

Integrated Orthopedic Physical Therapy, LLC
Patient Intake Form

Name: _____ **Date:** _____ **AGE:** _____ DOB: _____

Referring Physician: _____ Primary Physician _____
Diagnosis: _____ Next doctor's appointment_____

E-mail address_____
Height: _____ Weight: _____
Occupation: _____
Recreational Activities: _____

Have you **fallen** in the **past year**? ____ Yes ____ No
(If yes) Why and how many times? _____

Have you or anyone in your immediate family (parents, brothers/sisters) been diagnosed with any of the following? (Please mark all that apply)

	You:	Family:		You:	Family:
Cancer	☐	_____	Anemia	☐	_____
Diabetes	☐	_____	lung problems/SOB	☐	_____
Heart attack/ MI	☐	_____	Pneumonia	☐	_____
high blood pressure	☐	_____	Tuberculosis	☐	_____
COPD	☐	_____	Depression	☐	_____
Thyroid problems	☐	_____	drug/alcohol use/dependency	☐	_____
Osteoporosis	☐	_____	PTSD	☐	_____
Osteoarthritis	☐	_____	head injury/TBI	☐	_____
Rheumatoid arthritis	☐	_____	Concussion	☐	_____
Stroke/TIAs	☐	_____	Multiple Sclerosis	☐	_____
edema/swelling in legs	☐	_____	Fibromyalgia	☐	_____
chest pain/angina	☐	_____	Epilepsy/seizures	☐	_____
blood clots/aneurysm	☐	_____	Immune-suppression	☐	_____
Peripheral Artery Disease	☐	_____	OTHER	☐	_____
broken bones/fractures	☐	_____	OTHER	☐	_____

Do you smoke/use tobacco? Yes No How long_____ When did you stop?_____
Do you have a pacemaker? Yes No

At the present time would you say your health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list any surgeries, conditions or injuries for which you have been hospitalized/sought treatment: (dates if possible)
☐ **See attached list**
1. _____ 2. _____ 3. _____

Medications: (Prescription, OTC and Herbal and Natural Supplements)

☐ **See attached list** or list below

Medication	**Dosage**	**Usage per day**

ALLERGIES: *List any allergies or medication(s) you are allergic to*:

_____

Are you **latex** sensitive? Yes No

Have you ever taken steroid medications for any medical conditions? Yes No

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? Yes No

Have you ever been involved in a major trauma or motor vehicle accident? Yes No

Male: Have you been diagnosed with prostate disease? Yes No
Female: Is there a possibility that you are pregnant? Yes No
Have you been diagnosed with any OB/GYN difficulties? Yes No
If yes please describe_____

_____

CURRENT CONDITION:

When did your present symptoms begin?_____

What happened? _____

Your symptoms are currently: Getting Better ☐ Getting Worse ☐ Staying about the same ☐

Have you ever had this problem before? No YES When_____
Treatment received_____How long did it take for you to feel better? _____

Using the 0 to 10 the scale, with ***0*** being *"no pain"* and **10** being the *"worst pain imaginable"* please rate:

- Your **current** level of pain while completing this form: _____
- The **best** your pain has been during the past 24 hours: _____
- The **worst** your pain has been during the past 24 hours: _____

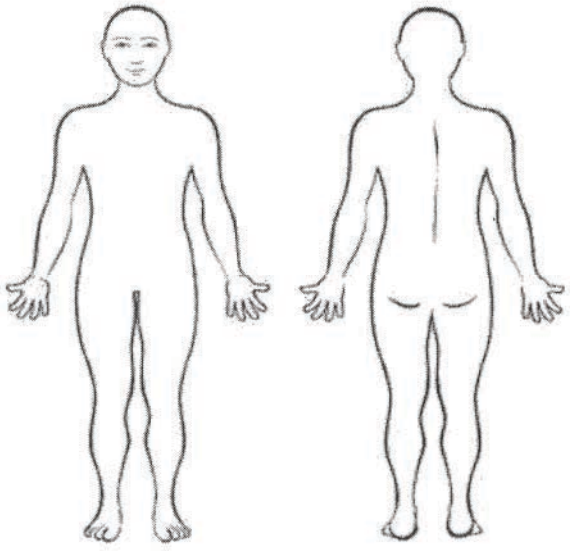
When are your symptoms **WORST**? ☐morning ☐afternoon ☐evening ☐night ☐after exercise
When are your symptoms the **BEST**? ☐morning ☐afternoon ☐evening ☐night ☐after exercise

Body Chart:

Please use the following symbols to show where and how to describe your symptoms:

↓ ***Shooting/sharp pain***
O Dull/aching pain
/// Numbness
= Tingling

My current symptoms:
☐ Come and go
☐ Are Constant
☐ Are constant, but change with activity



Please circle special tests performed for this problem: X-RAY MRI C-Scan Bone Scan EMG