400 BOSTON POST ROAD ORANGE, CT 06477

FINANCIAL POLICY AUTHORIZATION AND AGREEMENT

1. a. ASSIGNMENT OF BENEFITS: I hereby authorize payment of medical benefits to Ronai Physical Therapy & Sports Medicine, LLC and certify that all sums assigned, including Automobile Personal Insurance Protection, be sent directly to Ronai Physical Therapy & Sports Medicine, LLC. In the event my insurance company does not honor this request, I take responsibility for payment of my bill in full. As a courtesy, Ronai Physical Therapy & Sports Medicine, LLC assists with insurance benefit verification, however, carriers routinely review claims and change payment and medical necessity determination. In addition, I am aware that coverage may be reduced by services received at another provider. I am ultimately responsible for my benefit information as it pertains to my condition. The benefit information of coverage is not a guarantee of payment by an insurance carrier.

b. SELF - PAY: I have agreed to self-pay for the treatment program(s) listed below for the reason indicated below. I am aware that Ronai Physical Therapy & Sports Medicine, LLC will not bill these services to insurance carrier(s).

Treatment Program(s): _____

Reasons for Self-Pay: ( ) No Insurance ( ) No Benefit coverage ( ) Benefits Exhausted ( ) Out of Network Benefits

2. PAYMENT RESPONSIBILITY: I understand that I am responsible to pay co-payments required by my insurance at the time of each visit as well as any accrued deductible, coinsurance, and/or non-covered service) s) balances that have been processed by insurance to date. *I am aware that a billing fee may be incurred if such payment is not made upon first request. A charge may also be assessed for any broken appointments unless 24 hours notice is given.* For your convenience, Ronai Physical Therapy & Sports Medicine, LLC will accept cash, check or credit card as payment. I also understand that a billing fee may be incurred if such payment is not made on the day services are rendered. The parent and /or guardian of a minor are responsible for payment in full for services rendered and should be the signed guarantor. I understand that I am responsible to immediately inform your office of any changes to my insurance coverage and/or demographic information in order to comply with authorization requirements and filing limitation guidelines of my plan. Therefore, I understand that if I fail to notify your office of any changes prior to services rendered, I will be required to make payment in full for any non-covered service

3. EVALUATION AND TREATMENT AUTHORIZATION: I hereby authorize Ronai Physical Therapy & Sports Medicine, LLC, upon the written order of my physician, to evaluate and treat the condition(s) for which I am being referred.

4. AUTHORIZATION FOR TREATMENT OF A MINOR: I, _____ (parent/guardian), authorize Ronai Physical Therapy & Sports Medicine, LLC to evaluate and treat my son/daughter/charge (circle one) _____(name of client). This does/does not (circle one) include my permission to evaluate and treat the above named minor in my absence.

☐ **MEDICARE PATIENTS:** Ronai Physical Therapy & Sports Medicine, LLC provided me information explaining the Outpatient Therapy Caps.

☐ **I am not currently receiving any homecare services and will inform Ronai Physical Therapy & Sports Medicine, LLC prior to any homecare services being instituted.**

☐ **I am currently receiving homecare services and have provided Ronai Physical Therapy & Sports Medicine, LLC with the appropriate information**

☐ **DIRECT ACCESS PATIENTS:** I understand that if my insurance company does not reimburse Ronai Physical Therapy & Sports Medicine, LLC for my evaluation without physician orders then I will be charged a fee of $195

Thank you for reading our Financial Policy. Please let us know if you have any questions or concerns. I HAVE READ THIS FINANCIAL POLICY FOR RONAI PHYSICAL THERAPY & SPORTS MEDICINE, LLC AND I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

Signature: _____Date_____ Printed Name: _____
If Client is not financially responsible, please have the financially responsible party sign and date below:

Responsible Party: _____Date_____ Printed Name: _____

Relationship to client: _____ *Provide Responsible Party SSN# to Office
Explanation of why client did not sign: _____

Witness' Signature: _____ _____
(Ronai Physical Therapy & Sports Medicine, LLC employee will witness) Date

If the client has not signed this Financial Policy Authorization and Agreement, please print the responsible party's name, relationship to the client and explain why the client did not sign. The responsible party assumes full financial responsibility for the account balance. The statement should demonstrate that the above signer is authorized to consent to release client information on behalf of the client.

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PATIENT INFORMATION

CLIENT NAME: _____ DATE OF BIRTH: _____

ACCIDENT RELATED? (Please circle one) YES NO

IF ACCIDENT RELATED, PLEASE ANSWER THE FOLLOWING QUESTIONS:

DATE OF ACCIDENT: _____

TYPE OF ACCIDENT: (Please circle) MOTOR VEHICLE WORK SLIP/FALL ACCIDENT

HOW/WHERE ACCIDENT OCCURRED: _____

INSURANCE COMPANY: _____ CLAIM NUMBER: _____

HAVE YOU RETAINED AN ATTORNEY REGARDING THIS ACCIDENT? YES NO

NAME OF ATTORNEY/LAW OFFICE: _____

ADDRESS OF LAW OFFICE: ___ _____

_____

ATTORNEY PHONE NUMBER: _____

WRITTEN ACKNOWLEDGEMENT – NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered a Notice of Privacy Practices for RONAI PHYSICAL THERAPY & SPORTS MEDICINE, LLC. I understand that if I have further questions or complaints about the Privacy Notice I may contact:

Susan Ronai, Privacy Officer at (203) 799-3343

I also understand that I am entitled to receive updates upon request if this Notice of Privacy Practices of RONAI PHYSICAL THERAPY & SPORTS MEDICINE, LLC is amended or changed in a material way.

_____ or _____

Patient's Signature Patient's Personal Representative

_____

Date

TO BE COMPLETED BY RONAI PHYSICAL THERAPY & SPORTS MEDICNE, LLC.
IF UNABLE TO OBTAIN THE ABOVE ACKNOWLEDGEMENT

On _____ I attempted to obtain the above written acknowledgement, however the patient declined to sign.
(Date)

_____

Signature of Employee

_____ _____

Title of Employee Date