HEALTHY CORE
WELLNESS & REHAB, LTD.

FINANCIAL POLICY AND CONSENT

I give consent for treatment and acknowledge full financial responsibility for services rendered by Healthy Core. **I understand that payment is due at the time of service unless my insurance carrier is contracted with Healthy Core** or other arrangements have been made prior to treatment. If my insurance carrier is considered out-of-network, Healthy Core will submit the claim on my behalf and I will receive reimbursement directly from my insurance carrier. I understand that it is my responsibility to understand my insurance coverage and benefits. **I also understand that payment is not guaranteed from my insurance carrier.**

I authorize Healthy Core for the disclosure of Protected Health Information for the purposes of treatment, payment and health care operations and agree to full financial responsibility for any and all amounts not paid within 30 days past the date of invoice and/or cancellation fees. I agree to update Healthy Core of any changes to my address, phone number, email or health insurance, if applicable. I agree to pay any insufficient fund bank fees, attorney fees, collection fees and/or court costs in the event of default of payment for my treatment. **I agree to forward any and all payment to Healthy Core from my insurance carrier <u>beyond</u> the amount paid at the time of service, if applicable.**

I agree that I must provide **24 hours** notice of the need to cancel an appointment. I agree that if I cancel my appointment in less than 24 business hours or do not show for my scheduled appointment, I am responsible to pay the**$25 late cancel fee,** which must be paid before being seen for my next appointment. I also understand that I will be **removed from all future appointments** in the event that **I fail to show or give sufficient notice within two consecutive appointments.** I understand any email or phone call reminder that I may receive about my appointment is a *courtesy* of Healthy Core and that **I am responsible for all the appointments that I make.**

<u>Medicare patients</u>: Medicare rates are set by CMS and reimbursement is typically 80% for traditional plans and varies for Advantage plans. It is *your* responsibility to keep track of your annual physical therapy cap of $1900 for PT/ST (physical therapy/speech therapy) services you might have received elsewhere. Healthy Core will keep track of the annual cap for services rendered at *our* clinic.

I have read and fully understand the above policy and agree to financial responsibility.

Patient Name _____ Date _____

Patient Signature _____

Guardian Signature (if patient is a minor) _____