

Patient Information

Snyder Physical Therapy – New West Orthopaedic & Sports Rehabilitation, LLC

Patient Financial Policy

Please initial next to one of the following payment agreements:

_____ **Commercial Insurance Carriers:** _____ **Policy Holder:** _____ **Date of Birth:** _____

I am covered by one of the listed insurance plans and hereby authorize all payments go directly to Snyder Physical Therapy – New West Orthopaedic & Sports Rehabilitation (SPT–NWR). I agree to pay the amount my insurance plan indicates I am responsible for at the time of service. I agree to provide written authorization prior to my receiving treatment if this is required by my insurance plan.

*Blue Cross Blue Shield

*Cigna

*Coventry Healthcare

*Humana

*Midlands Choice

* Mutual of Omaha

*TriWest/TriCare

* United Healthcare

_____ **Other Insurance:** I am covered by an insurance plan that is not listed and hereby authorize all payments to go directly to SPT-NWR. I will pay the portion that my insurance indicates is my responsibility at the time of service.

_____ **Medicare:** I am a Medicare recipient, and understand that SPT–NWR accepts assignment of Medicare claims. The Medicare Physical Therapy/SLP cap for 2018 is \$2010 per year. I understand that SPT–NWR will file my claims for me to both my Medicare and secondary insurance. ** *Have you used any cap amount for 2018?* Y or N if Yes, how much: \$_____ Visit(s): _____

_____ **Medicaid:** I am covered by Medicaid and verify that my coverage is active. If my eligibility status changes I will let SPT–NWR know. I understand that if I am seen without coverage I am responsible for the charges incurred. Should my Medicaid plan have a co-pay or deductible requirement, I agree to make payment at the time of service.

_____ **No Insurance:** I have no assignable third party coverage and will pay at the time of services rendered. I understand that SPT – NWR will not file an insurance claim for my services.

_____ **Law Suit/Liability:** Although I am involved in litigation, I am responsible for payment of my account upon the date of services rendered. I understand that SPT-NWR will not wait for payment from any settlement I may or may not receive in the future.

** **Fill out Liability Form**

_____ **Workers Compensation:** I have a work related injury. SPT-NWR will bill my employer for the services rendered, and in the event of a dispute with my employer about the work-relatedness of my injury, I accept full responsibility for payment of my account. I will provide a copy of my personal health insurance card to SPT-NWR. ** **Fill out WC Form**

Please initial all five lines below:

_____ **Consent to Treat:** I understand that by initialing I am giving permission for evaluation and treatment by SPT-NWR and that I have the right to refuse any procedures after having the risks and benefits explained to me.

_____ **Assignment of Benefits:** I hereby authorize SPT-NWR to furnish information to the above-named insurance carrier(s) concerning my treatment and hereby assign to the therapist(s) all payments for service rendered. I understand that I am responsible for all charges, even those not paid by my insurance.

_____ **Medical Authorization:** I hereby authorize release of any and all medical records to SPT-NWR. I also consent to the release of my health care records to be reviewed by my insurance company or any necessary audits within SPT-NWR.

I authorize SPT-NWR to release information to: _____

_____ **HIPAA Notice of Privacy Practice:** I acknowledge that SPT-NWR has offered or supplied me with a copy of their HIPAA Notice of Privacy Practice regarding policies and procedures concerning my Protected Health Information (PHI). I agree to release authorization to SPT-NWR to use my PHI as deemed necessary for treatment, billing and the purposes mentioned in the notice.

_____ **Monthly Statement:** I acknowledge that a Patient Account Statement will be sent at the end of the month from our parent company New West Orthopaedic & Sports Rehabilitation, LLC, located in Kearney, NE. If you have any questions regarding your statement feel free to call the Lincoln office, 402/489-1999 or the Kearney office at 308/237-7388.

Signature: _____ **Date:** _____

Patient or Legal Guardian (if patient is under 18 years old)