MED STAR
SPECIALIST CLINIC

**Attendance Policy -** Our number one priority is to help you improve your condition quickly and effectively. With the exception of a serious emergency, it is expected that you keep all prescribed appointments so that we may service you to the highest level, and ensure that you do not lose any progress in your rehabilitation program. If you need to reschedule an appointment, we require 12 hours' notice since this appointment time has been specifically reserved for you. In such a case, please call our office and reschedule your appointment with our front desk staff. Every attempt should be made to make up the appointment, preferably within the same week to help you achieve the best results from your treatment plan and prevent any setbacks in your progress.

**Insurance Referrals –** If your insurance plan requires a referral from your Primary Care Physician (PCP), our staff will request one from your PCP on your behalf prior to starting treatments as a courtesy. Ultimately, it is your responsibility to obtain that insurance required referral from your PCP in order to receive benefits coverage for Outpatient Physical Therapy Services under your plan. If your insurance company denies payment of your visit due to the fact that an appropriate and valid referral was not on file at time of service, we do reserve the right to bill you for that date of service at our self-pay discount rates.

**Financial Policy -** We verify insurance benefits as a courtesy to you, however, it is your responsibility as the member to be aware of your coverage, plan limitations, and coordination of benefits. A quote of benefits is not a guarantee of payment and coverage is subject to change upon claims processing. You are responsible for paying all deductibles/coinsurance/copayments under your insurance plan(s) for all services provided to you at the time of service. This is a legal requirement when receiving healthcare services and failure to meet your obligations is a violation of the agreement with your insurance carrier and federal law. Your insurance carrier may also take additional action. In the event that no insurance benefits pay for your services, you are responsible for payment and will be billed at our self-pay discount rates as stated above. In the event of non-payment, MEDSTAR Specialist Clinic. will turn the account over to a collection agency which may result in additional fees accumulating on the balance.

**Benefit Assignment/Release of Information -** I hereby assign all medical benefits including major medical benefits to which I am entitled under Medicare, Private Health Insurances, MedPay, PIP and Third Party Payers payable directly to MEDSTAR Specialist Clinic. for any/all services rendered to me and billed on HCFA1500 forms on my behalf. A photocopy of this assignment is to be considered as valid as the original. I do hereby authorize MEDSTAR Specialist Clinic. to release any/all information as may be necessary and required in the billing process to facilitate and secure payment for medical expenses incurred by me.

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**Acknowledgement of Notice of HIPAA -** My signature indicates that I have been provided with a copy of the notice of privacy practices and am aware of my rights and protections under such.

**Consent for Treatment -** I request and give my consent for MEDSTAR Specialist Clinic. to provide me with medical care and treatment considered necessary and proper in diagnosing or treating my physical condition. I understand that I am requesting these services at my discretion and as such am responsible for communicating any and all important information to my therapist and/or office staff as may be required or necessary for the individual needs of my treatment plan and billing processes including but not limited to, pain levels, medical history, comfort levels, treatment goals, insurance information, change of address, name, etc.

**My signature below acknowledges that I have reviewed and understand the above policies and herby give my consent to the same. I understand that I am seeking services from MEDSTAR Specialist Clinic. of my own volition and in cooperation with the above policies and procedures.**

**Patient Signature**: _____ **Date:** _____

**Parent/Guardian:** _____ **Dependents Name:** _____

***Witnessed by MEDSTAR Specialist Clinic Staff:*** _____ **Copy to patient** ☐ Yes ☐ No