EST. 2008
ORTHOPEDIC EDGE
PHYSICAL THERAPY

orthopedicedge.com | 586.566.5116

Patient Consent and Acknowledgment: Billing Procedures

Please read this form carefully. Ask any member of our staff if you have questions before signing.

Patient Information

Patient name: _____ Date of birth: _____

Responsible party (if different from patient): _____ Relationship to patient: _____

1. Insurance Information and Authorization

I have provided accurate and complete insurance information to Orthopedic Edge Physical Therapy. I will tell the Practice right away about any change to my coverage, address, or phone number. I understand that the Practice will bill my insurance as a courtesy, but that billing my insurance does not guarantee payment.

I understand that some plans require a physician referral, prior authorization, or a limit on the number of visits. I understand that I am responsible for knowing the terms of my plan, and that the Practice may verify my benefits but cannot guarantee what my plan will cover.

2. Assignment of Benefits

I authorize my insurance carrier to pay benefits directly to the Practice for services provided to me. I understand that I remain responsible for any amount my insurance does not pay.

3. Patient Financial Responsibility

I understand that I am responsible for:

- Copayments, due at the time of service
- Deductibles and coinsurance, as determined by my insurance carrier
- Services that my insurance denies, does not cover, or considers not medically necessary
- Charges for visits beyond my plan's covered limits
- Any balance remaining after my insurance has processed the claim

If my claim is denied because of incomplete or inaccurate information that I provided, I understand I will be responsible for the full charge.

4. Self-Pay Patients

If I do not have insurance, or I choose not to use it, I agree to pay the Practice's self-pay rate. Payment is due at the time of service unless I have made other arrangements in writing. Self-pay rate: $75 per visit.

5. Work-Related and Auto Accident Injuries

If my condition is the result of a work injury or an auto accident, I will give the Practice the claim number, adjuster contact, and authorization information before my first visit. I understand that if the claim is denied or delayed, I am responsible for charges unless other arrangements have been made in writing.

6. Payment Methods and Statements

The Practice accepts [cash, check, major credit and debit cards, HSA/FSA cards]. Statements are sent monthly by email or mail, whichever I prefer, and balances are due within [30] days of the statement date unless a payment plan has been agreed to in writing. A fee of $25 may be charged for returned checks.

I would like to receive my statements by:

[ ] Email: _____

[ ] Mail (to the address on file)

7. Past-Due Accounts

I understand that if my account is 120 days past due, I have not set up a payment plan with the billing office, and the Practice has made three unsuccessful attempts to reach me, my account will be referred to a collection agency.

8. Consent to Share Information for Billing

I authorize the Practice to release my health information as needed to process claims, obtain payment, and communicate with my insurance carrier, referring provider, billing service, and collection agency. This is described further in the Practice's Notice of Privacy Practices.

9. Billing Questions and Disputes

If I have a question about my bill, I may contact the billing office at 586.566.5116. I understand that I should raise any concern within [60] days of receiving a statement so that it can be reviewed promptly.

Acknowledgment and Signature

By signing below, I confirm that:

- I have read and understand this form, and my questions have been answered.
- I agree to the billing and payment terms described above.
- I have been offered a copy of this form.
- I am signing voluntarily.

Patient signature: _____

Date: _____ Printed name: _____

For office use only

# of PT visits: _____ Deductible: _____ Copay: _____