PATIENT RESPONSIBILITY

As a patient of Berryville Physical Therapy & Wellness, PLC, I agree that I am responsible for any unmet deductible, co-insurance, and/or any unpaid balances. This includes all insurance companies, workman's compensation and auto claims.

***As a courtesy, we make every effort to know your insurance benefits when you are a patient here but every policy varies in coverage. Therefore it is your responsibility to confirm benefit information. ***There is a $25 returned check fee that insurance is not responsible for.

Medicare patients who do not have supplemental coverage are responsible for any unmet deductible, non-covered services, or co-insurance amounts. Some supplemental policies have a co-pay or deductible of their own; patients are responsible for that amount.

*All uninsured patients and patients who are denied physical therapy coverage by their insurance company are responsible for our cash price.

*If the patient is unable to pay the full amount of his/her bill them payment arrangements will be made on a case by case basis.

*I understand if payment arrangements have not been made, and my account is still outstanding (90) days from the 1st billing cycle, my account may be referred to a collection agency or and attorney for collection. I agree to pay all costs of collection, including but not limited to, 40% collection fees, registered mail fees, court costs actually incurred in the collection of the amount whether or not a suit is filed, and any other fees or cost incurred during the collection process.

*I understand that I am responsible for my account even if I receive a late notification of my outstanding balance. In this case, I will not be referred to a collection agency and will be allowed to make arrangements for a payment plan.

When all payments have been made by the account responsible and the insurance company (ies), if there is a credit or debit balance of less than $1, I understand that Berryville Physical Therapy & Wellness will consider the account closed and will neither pursue collection nor refund the balance.

"NO SHOW / LATE CANCELLATION" POLICIES

*If you are unable to keep your appointment we would like to be notified 24 hour before your scheduled appointment. We understand that 24 hours is not always possible, therefore we give grace for one "no show" before a $25.00 "no show/no call charge will be added to your account and will be due in full at the time of your next scheduled appointment. This charge is not covered by your insurance. We reserve the right to waive this fee if we feel the circumstances warrant.
* If a patient has a no show 3 times in a row, or has 3 late cancellations, they will be removed from the schedule. We reserve the right to waive this policy if needed

PRIVACY NOTICE SUMMARY

ALL MEDICAL INFORMATION ABOUT YOU IS REGARDED AS PROTECTED HEALTH INFORMAITON (PHI) AND IS TREATED AS CONFIDENTIAL AND WILL BE RELEASED ONLY TO THOSE AUTHORIZED TO RECEIVE IT.

PROTECTED HEALTH INFORMATION WILL BE DISCLOSED FOR THE TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS TO:

- YOU OR SOMEONE YOU HAVE APPROVED TO RECEIVE IT AND/OR SOMEONE THAT HAS THE LEGAL RIGHT TO ACT IN YOUR BEHALF.
- MEDICARE, HEALTH INSURANCE PLANS, WORKERS COMPENSATION INSURANCE AND OTHER PAYERS, FOR BILLING PUPOSES.
- REFERRING MEDICAL PRACTICES TO REPORT EVALUATIONS, TREATMENTS, PROGRESS, RECOMMENDATIONS AND CHANGES.
- INTERNS AND/OR STUDENTS PURSING A CAREER IN PHYSICAL THERAPY OR ATHLETIC TRAINING THAT ARE TEMPORARILY PRESENT IN THE PRACTICE.
- WHERE REQUIRED BY FEDERAL, STATE OR LOCAL LAW.

BERRYVILLE PHYSICAL THERAPY AND WELLNESS, PLC MAY USE OR GIVE OUT PHI FOR THE FOLLOWING PURPOSES UNDER LIMITED CIRCUMSTANCES:

- FOR JUDICIAL AND ADMINISTRATIVE PROCEDEINGS IN RESPONSE TO COURT ORDER.
- FOR RESEARCH STUDIES THAT MEET ALL PRIVACY LAW REQUIREMENTS.

YOUR AUTHORIZATION (SIGNATURE) IS REQUIRED TO USE OR GIVE OUT YOUR PROTECTED HEALTH INFORMATION FOR ANY PURPOSE THAT IS NOT SET OUT IN THIS NOTICE.

YOUR AUTHORIZATION (SIGNATURE) IS REQUIRED TO LIMIT THE DISCLOSURE PH PHI BY IDENTIFYLING TO WHOM IT SHALL NOT BE RELEASED AND/OR THE CONTENT THAT SHALL NOT BE RELEASED.

UPON REQUEST TO THE OFFICE MANAGER, ARRANGEMENTS CAN BE MADE FOR YOU TO REVIEW OR RECEIVE A COPY OF YOUR MEDICAL INFORMATION. IF THERE IS ANY CONCERN REGARDING THIS INFORMATION, AN APPOINTMENT WILL BE SCHEDULED WITH THE ATTENDING PHYSICAL THERAPIST TO DISCUSS THE CONCERN. THE INFORMATION MAY BE AMENDED WHEN DEEMED APPROPRIATE.

UPON REQUEST YOU MAY RECEIVE AN ACCOUNTING OF DISCLOSURES. THIS IS A LIST TO WHOM INFORMATION HAS BEEN RELEASED.
SUBMIT ALL REQUESTS TO THE OFFICE MANAGER.
A COPY OF THIS NOTICE OR THE COMPLETE PRIVACY NOTICE IS AVAILABLE UPON REQUEST.

I have read and agree to the above statements.

________________________	________________________	____________
PATIENT NAME	PATIENT SIGNATURE	DATE