FINANCIAL POLICY for Altruistic Therapy Services, LLC

Welcome and thank you for choosing Altruistic Therapy Services, LLC. We are committed to providing you with the highest quality care in an efficient, timely, and effective manner. If you have any questions, please feel free to discuss them with our staff.

1. ***Insurance Coverage:*** *Your insurance policy is a contract between you and the insurance company. As a courtesy, we will file your insurance claim for you. This allows the insurance company to pay the Altruistic's office directly. We are a specialist office and it is always wise to verify your insurance benefits, co-pays, and deductibles prior to your visit or procedure. We will make a copy of your insurance card and driver's license during your initial visit. Existing patients are to inform us of any changes in insurance coverage or demographics that may have occurred since your previous visit.*
2. ***Co-Payments:*** *Most insurance plans have a Co-Payment (co-pay). This is an amount you must pay upon each visit to a specialist / doctor. Our policy is to collect your co-payment at the time of service. Sometimes, after we bill your insurance company, there will be additional OOP/ Copay costs which we will bill you for as well. If you are not prepared to pay the co-payment, the visit will be rescheduled. We accept Cash, Check, Debit Card, Visa, MasterCard and Discover.*
3. ***Deductibles:*** *In addition to the co-payment, most plans also have an annual deductible. If you have not met your deductible you will be billed for the anticipated approved insurance amount. Payment is expected at the time of service. In the event there is a balance due from you after your insurance carrier has paid its portion we will bill you. We would appreciate prompt payment of your bill after the first statement. If you do not understand the reason you owe a balance, please do not hesitate to contact our office, and the billing staff will explain the balance to you, and answer any questions you might have. If your account becomes past due, we will refer the overdue balance to an outside collection agency.*
4. ***Referrals:*** *If you are enrolled in an HMO, which requires a referral from your Primary Care Physician (PCP), it is your responsibility to make sure our office has a copy. You are responsible to keep track of the visits allowed and the expiration date of your referral. If a referral is not in place, your appointment may be rescheduled or any services received without a referral or proper authorization will be your financial responsibility.*
5. ***Non-Covered Services:*** *Your insurance plan may not cover all services and/or supplies provided to you during your treatment. In the event your health plan determines a service or item to be "non-covered", you will be responsible for total charges at time of visit or upon receipt of a statement from our office. Please acknowledges and understands that in the event payment in full is not received by*

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THERAPY SERVICES

FINANCIAL POLICY for Altruistic Therapy Services, LLC continued,

Altruistic Therapy Services, LLC upon final demand , you agree to pay all costs of collection including but not limited to, attorney's fees and court costs. All fees are due prior to services being rendered. If you need an invoice, one may be requested and provided. You also acknowledge that ***Altruistic Therapy Services, LLC is in no way responsible for the denial of services rendered.*** *If your insurance carrier is auto or workman's comp related, we will not continue services beyond a 45 day delay in payment from the date the initial claim was sent via certified mail to the carrier. You will be responsible for payment at that time. Altruistic will provide you with a receipt which you can submit in attempt to collect reimbursement.*

6. ***Private Pay Clients:*** *You acknowledged that if you are a private pay client, payment will be required at the time of service.*
7. ***Forms:*** *There will be a prepaid fee of $25 per form for completing any forms outside of Altruistic's paperwork to include medical forms, disability forms, work restriction forms, FMLA forms, employer forms, school forms, legal forms, to attorney, letter of medical necessity, insurance rebuttals, etc. Payment is due at the time that you request the forms to be completed. Please allow 7 business days for the completion of these forms. There will be a 10$ charge to copy and provide medical records.*
8. ***Returned Checks:*** *A $35 fee will be charged for any checks returned by the bank.*
9. ***Payments accepted:*** *Check, cash, credit card. A fee will apply for credit card payment.*

Please sign below if you have read, understand and agree to the above eight financial policies of Altruistic Therapy Services, LLC.. I understand that I am financially responsible for any deductible, co-insurance, co-pay, non-covered service or unmet balance and any other charges my insurance may not cover.

Signature of Patient or Responsible Person: _____

Printed Name: _____ *Date:* _____