Altruistic
THERAPY SERVICES

Authorization to Pay Benefits to Altruistic Therapy Services: *I hereby authorize payment directly to Altruistic Therapy Services, LLC of the Therapy benefits, if any, otherwise payable to me for their services as described below but do not exceed the reasonable and customary charge for those services. I understand the provider's charge may exceed the private insurance carrier payment, and if greater than such payment, I will be responsible for that amount, and /or any deductibles or co-pays.Payment is due at the time of service, unless arrangements are made in advance.*

Authorization to Release Information*: I hereby authorize Altruistic Therapy Services, LLC to release any information required by my health insurance company to pay my medical claims. As related to my examination and treatment.*

*Signature:*_____*Date:*_____

HIPAA Confirmation*: I confirm that I have received / downloaded the HIPAA documentation. If you have not yet downloaded the HIPAA documentation please visit the following link: https://www.altruisticsls.com/wp-content/uploads/2018/09/HIPAA.pdf*

*Signature:*_____*Date:*_____

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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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:* _____

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CONSENT FORM for Treatment, Payment and Healthcare Operations

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. ***Consent for Treatment:*** *I hereby authorize the attending therapist /practitioner at Altruistic Therapy Services, LLC to prescribe, administer, and perform such examinations, and treatment as necessary or advisable in the diagnosis and treatment of my condition. I understand that the practice of therapy is not an exact science and acknowledge that no guarantees have been or will be made regarding the results of examinations or treatments in this clinic.*
2. ***Legal Relationship between Altruistic Therapy Services, LLC and therapists:*** *Some of the professional therapists performing services for Altruistic Therapy Services, LLC are independent contractors and are not agents or employees of Altruistic Therapy Services, LLC. Independent contractors are responsible for their own actions and for identifying themselves to you as independent contractors, and Altruistic Therapy Services, LLC shall not be liable for the acts or omissions of any such independent contractors.*
3. ***Disclaimer of Guarantees:*** *I acknowledge that the practice of a therapy discipline is not an exact science and that treatment may involve the risk of adverse results and injury, I acknowledge that no guarantees have been made as to the results of therapeutic treatment (herein called "Treatments") that may be undertaken by Altruistic Therapy Services, LLC. While routinely performing without incidence, there may be material risk associated with each of these treatments. I understand that it is not possible to list every treatment or every risk for every treatment. I also understand that various professional therapists may have differing opinions as to what constitutes material risk associated with specific treatments.*
4. ***Assignment of Benefits:*** *In consideration of any services rendered to me by Altruistic Therapy Services, LLC, I hereby authorize and assign any and all reimbursement pertaining to said services to be made on my behalf and paid directly to Altruistic Therapy Services, LLC. If my insurance benefits are provided to me through Medicare, I hereby authorize and assign any and all reimbursement made under my Medicare plan which pertains to any services provided to me by Altruistic Therapy Services, LLC.*
5. ***Authorization to Release Information:*** *I authorize Altruistic therapy Services, LLC to release and disclose any Private Health Information about me that pertains to any and all medical care, tests, treatment, or advice that was rendered to me by the therapist and/or staff of Altruistic Therapy Services, LLC to any physicians, practitioners, insurance companies, third party payers, authorized agents, claims review organizations, support staff or facility involved in my plan of care or transfer of care and/or Medicare in order to process a claim and/or payment on my behalf. Please list additional persons, relationship and phone number:*

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6. ***HIPPA Notice of Privacy Practices:*** *I acknowledge that a copy of the Altruistic Therapy Services, LLC HIPPA Notice of Privacy Practices will be made available to me at my request, and that I have read, or had the opportunity to read if I so chose, and understand the Notice.* ***Please note that email is not HIPAA compliant. If you choose to communicate with Altruistic Therapy Services, LLC via email, please do so at your own risk. We encourage you to send any medical documentation via fax: 866-886-6628, mail or in person.***
7. ***Payment Agreement:*** *I understand that by providing a valid and current insurance card prior to services being rendered, Altruistic Therapy Services, LLC will file a claim to my insurance company but that does not guarantee payment which ultimately I am responsible for. I hereby accept and assume financial responsibility for any covered or non-covered services rendered to me and will be responsible for any services that are unpaid as a result of not providing Altruistic Therapy Services, LLC with a valid referral. If there are any questions, problems, or delays regarding my coverage and or benefits, I understand that it is my responsibility to solve these issues with my insurance carrier and the billing office administrator. Deductibles, co-payments, and payment for non-covered services will be due at the time of service.*

Please sign below if you have read, understand and agree to the above five statements.

*Signature of Patient or Responsible Person:*_____

Printed Name: _____ *Date:* _____

Altruistic
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CANCELLATION / NO SHOW / RESCHEDULE POLICY

Dear Patient,

We strive to provide excellent rehabilitative care to you, your family and all of our patients. In order to do so effectively and efficiently, we have developed an appointment system that sets asides ample time for a patient. When there are missed appointments, it greatly affects your progress and rehabilitation outcomes.

"No-shows", and late cancellations inconvenience those individuals who need access our services in a timely manner. In an effort to reduce the number of such occurrences, we have implemented a Cancellation Policy and it is effective immediately. We understand that emergencies and unfortunate events arise at times. Therefore we will allow a maximum of one courtesy cancellation which also must be re-scheduled within the same week.

Our policy is as follows:

1. We request you give our office a 24-hour notice in the event you need to reschedule your appointment.
2. You MUST call your therapist and a re-schedule must be attempted.
3. If you miss an appointment and do not contact us with at least a 24 hour prior notice, we will consider this a missed appointment and a **$50.00** fee will be assessed to you. This applies to late cancellations and "no-shows."
4. If you are late for an appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length.
5. It is ultimately the patient's responsibility to remember their scheduled appointments. This fee will be billed to you directly and **is not** covered by your insurance. This balance must be paid prior to your next appointment. If you don't have a scheduled appointment, the balance is expected in a timely fashion and if not, will be subject to collections.
6. Negligent compliance with scheduled sessions may result in an immediate discharge from our services and a letter will be sent to your referring physician explaining poor compliance with the plan of care.

We thank you for trusting Altruistic Therapy Services, LLC. with your medical care.
I have read and understand the **CANCELLATION / NO SHOW / RESCHEDULE POLICY** and agree to the terms of this policy.

Signature:_____

Printed Name:_____

Date:_____

0: 810.886.1028 f: 866 886 6628 124 S. State Rd. Davison MI 48423 altruisticsls.com

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CONSENT FORM for Treatment, Payment and Healthcare Operations

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3. ***Disclaimer of Guarantees:*** *I acknowledge that the practice of a therapy discipline is not an exact science and that treatment may involve the risk of adverse results and injury, I acknowledge that no guarantees have been made as to the results of therapeutic treatment (herein called "Treatments") that may be undertaken by Altruistic Therapy Services, LLC. While routinely performing without incidence, there may be material risk associated with each of these treatments. I understand that it is not possible to list every treatment or every risk for every treatment. I also understand that various professional therapists may have differing opinions as to what constitutes material risk associated with specific treatments.*
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5. ***Authorization to Release Information:*** *I authorize Altruistic therapy Services, LLC to release and disclose any Private Health Information about me that pertains to any and all medical care, tests, treatment, or advice that was rendered to me by the therapist and/or staff of Altruistic Therapy Services, LLC to any physicians, practitioners, insurance companies, third party payers, authorized agents, claims review organizations, support staff or facility involved in my plan of care or transfer of care and/or Medicare in order to process a claim and/or payment on my behalf. Please list additional persons, relationship and phone number:*

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6. ***HIPPA Notice of Privacy Practices:*** *I acknowledge that a copy of the Altruistic Therapy Services, LLC HIPPA Notice of Privacy Practices will be made available to me at my request, and that I have read, or had the opportunity to read if I so chose, and understand the Notice.* ***Please note that email is not HIPAA compliant. If you choose to communicate with Altruistic Therapy Services, LLC via email, please do so at your own risk. We encourage you to send any medical documentation via fax: 866-886-6628, mail or in person.***
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Printed Name: _____ *Date:* _____