Altruistic
THERAPY SERVICES

TO BE COMPLETED AND RETURNED TO US. WE WILL NOT PROCESS YOUR PAPERWORK WITHOUT ALL THESE ITEMS AND ALL SECTIONS BEING INITIALLED. IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CALL US.

I understand that Altruistic Therapy Services LLC request than any patient information **be faxed to 866-886-6628**. It is at the patient's discretion to send any personal or medical information via emails and that email is not HIPAA compliant. _____

I have provided a copy of the guarantor / subscriber's driver's license and a copy of the front and back of the insurance card. _____

I have requested a script from my PCP (primary care physician) and have forwarded to Altruistic Therapy Services, LLC. I understand my session will be cancelled without it. _____

PICK ONE:

☐ **I am opting out of using my insurance and am paying privately: _____**

☐ **I am using my insurance and have called my insurance company and verify our benefits as listed below for services being rendered. _____**

Date of Phone Call: _____
Name of representative: _____
Reference ID: _____
Number per visits / calendar year_____
Deductible: _____
Co/Pay: _____

I have a read all the policies regarding consent of treatment, **financial responsibilities**, **cancellations**, insurance responsibilities, additional charges for filling out paperwork or copies of forms / medical records requested AT ANY TIME, and anything requested or handled outside of my treatment session to include phone calls that would be non-covered costs by my insurance that **will be billed directly to me by my provider at 120$/hour prorated at a minimum of 15 minute increment**s excluding communication regarding cancellations and reschedules which can be communicated directly to the therapist. _____

Signature: _____ Date: _____

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Patient Verification / Financial Information

Patient's Name: _____ DOB: _____
Address: _____City: _____Zip: _____
Phone: _____Cell: _____

Primary Care or Referring Physician_____
Address_____
Office Phone: _____
Fax:_____

Person Responsible for bill or parent (Complete only if different from the patient)
Guarantor Name: _____
DOB:_____
Social Security Number_____
Address: _____
Phone: _____
Relationship to patent: ( ) Self ( )Spouse ( ) Parent ( ) Other _____
If the patient is a minor, please state custodial parent's name: _____
If the patient is a minor, are there any custody issues? Y_____ N _____

Patient Elect to Private Pay

I understand that by electing to self-pay for services, this may mean I forgo my opportunity to have any claims sent to my insurance by Altruistic Therapy Services for the remainder of the coverage year. _____

Signature of Person Filling out this form: _____

If you have opted for private pay, please skip to the next page, fill in patient name, sign and date.

Primary Insurance: - IF NOT AUTO OR WORKERS COMP RELATED
Name: _____
Subscriber Name: _____
Contract Number: _____Group Number: _____

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Secondary Insurance:
Name: _____
Subscriber Name: _____Contract Number: _____
Group Number: _____

Third Insurance:
Name: _____
Subscriber Name: _____ Contract Number: _____
Group Number: _____

If Auto or Workers Comp Related:
Auto: _____WC: _____DOI: _____
Claim Number: _____
Insurance Carrier: _____
Authorization to Charge for Private Pay

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. 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.

_____

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._____

Patient's Name _____
Caregivers/ Parent's / Guardian's Signature: _____
Printed Name: _____ Date: _____

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Financial Policy:

I agree to the following as applicable:

Payment **is due at the time of service** unless arrangements are made in advance.
_____

I understand that Altruistic Therapy Services, LLC uses an outside billing company and that **all billing** is reviewed and controlled by them. If I have any questions, I can request a call from the billing department. Altruistic Therapy Services, LLC will do their best to resolve any questions, but billing for cancellations and any additional paperwork aside from patient's daily treatment notes are **non-negotiable**. _____

I understand that **my insurance carrier could at any point during and post treatment recoup payment from Altruistic Therapy Services, LLC of which I will be fully responsible to pay** Altruistic Therapy Services, LLC, what is customary and reasonable for services that were rendered by Altruistic Therapy Services, LLC. _____

I am responsible to check and verify my insurance benefits, co-pays, and deductibles prior to my visit or procedure. _____

I am responsible to pay **non-covered services, co-pays, out of pocket costs and/or deductibles** to Altruistic Therapy Services, LLC when due and if I have any questions, I understand that I must still pay my invoice and have the right to call my insurance with any questions or concerns. _____

I understand and agree to pay all costs of collection including but not limited to, attorney's fees and court costs. _____

I understand that 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. _____

I understand that Altruistic Therapy Services, LLC will not continue services beyond a 45-day delay in payment from the date the initial claim was sent via certified mail and 20 days via electronic billing. I will be responsible for payment at that time. Altruistic Therapy Services, LLC will provide me with a receipt which I can submit in attempt to collect

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reimbursement. If Altruistic Therapy Services, LLC is reimbursed after my payment, they will refund me accordingly. _____

I understand and acknowledge that if I am a private pay client, payment will be required at the time of service. _____

REGARDING ANY ADDITIONAL PAPERWORK OR CORRESPONDENCE OUTSIDE OF TREATMENT WITH MY PROVIDER:

I understand that there will be a **prepaid fee of $25** per form for completing any forms outside of Altruistic's paperwork **to include medical forms, disability forms, work restriction forms, FMLA forms, employer, forms, school forms, legal forms, to attorney and any letter of medical necessity and/or including insurance rebuttals will be billed at 120$ to the provider in 15 minute increments at the prorated rate.** 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. **This means that if any forms are requested during or after you are discharged, you will be required to pay us prior to release of any forms. _____**

I understand that there will be a **15$ charge** for any copies of medical records. _____

I understand that **any returned Checks**: A **$35 fee** will be charged for any checks returned by the bank and that checks will not be held.

I understand that any additional time requested by me with my provider outside of my sessions to include phone calls and any additional **non – covered services by my insurance carrier will be billed at 120$ / hour and prorated at a minimum of 15 min increments**. _____

I understand that no texting outside of sessions will occur about anything patient related except scheduling / cancellations which will be communicated directly with my therapist.
_____

Patient's Name _____
Caregivers/ Parent's / Guardian's Signature: _____
Printed Name: _____Date: _____

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CONSENT FORM for Treatment

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. I understand that this consent does not mean I will receive teletherapy as a primary way of treatment, but that it allows for the option of this form of treatment if deemed appropriate by the therapist and patient and/or family.

_____

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5. I authorize and voluntarily consent to the participation and treatment of myself and/or child in a HIPAA compliant teletherapy consultation and/or treatment with Altruistic Therapy Services, LLC if needed. _____

Patient's Name _____
Caregivers/ Parent's / Guardian's Signature: _____
Printed Name: _____Date: _____

RELEASE OF MEDICAL INFORMATION:

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.

1._____
2._____
3._____
4._____

Patient's Name _____
Caregivers/ Parent's / Guardian's Signature: _____
Printed Name: _____Date: _____

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CANCELLATION / NO SHOW / RESCHEDULE POLICY

I understand I must provide 48-hour notice and am provided with a **one-time** courtesy cancellation at no cost. _____

I understand that all cancellations less than 48-hour notice from the time of my appointment will be charged at a rate of $50.00 which will be due immediately.

_____

I understand that other than massage therapy, we provide zoom as an alternative to sessions that may be cancelled due to sicknesses, and it will be offered to me if appropriate. _____

I understand if I am late for my appointment, I will be seen as soon as possible, though the office visit may need to be shortened in length. _____

I understand that it is ultimately my responsibility to remember my scheduled appointments. The fee will be billed to me directly and is not covered by my insurance. This balance must be paid prior to my next appointment. The balance is expected in a timely fashion and if not, will be subject to collections. _____

I understand that negligent compliance with scheduled sessions may result in an immediate discharge from services and a letter will be sent to my referring physician explaining poor compliance with the plan of care. _____

I understand that Altruistic Therapy Services, LLC uses an outside billing company and that **all billing** is reviewed and controlled by them. If I have any questions, I can request a call from the billing department. Altruistic Therapy Services, LLC will do their best to resolve any questions, but billing for cancellations and any additional paperwork aside from patient's daily treatment notes are **non-negotiable.** _____

Patient's Name _____
Caregivers/ Parent's / Guardian's Signature: _____
Printed Name: _____Date: _____