Hand Therapy Associates Office Policies Agreement

CANCELLATION POLICY: 24-hour notice must be provided in the event you cannot keep an appointment. Should you fail to provide this notice, a cancellation fee of **$50.00** may be added to your account. **This will be billed directly to the patient or guarantor.** For Workmen's Compensation claims, we are required to notify your case manager of any cancellations/no shows.

COPAYMENTS, COINSURANCE AND DEDUCTIBLES: You are responsible for the payment of any amount that your insurance carrier deems to be copayment, coinsurance or deductible. Due to our contractual obligations with your insurance company, we ARE NOT able to write off copays, coinsurance and deductibles. **PAYMENT IS EXPECTED AT THE TIME OF SERVICE.**

Please note: Your insurance plan is a legal contract between you and your insurance company. We are not responsible for, or in control of, what services your insurance company will pay for or the amount your insurance company will reimburse for services rendered. It is your responsibility to know the details of what your plan covers.

ACCOUNT BALANCES: All balances billed to you are due within 30 days of the bill date. If you choose to delay payment you will incur 1.5% interest on your account monthly. Accounts that are 90 days past due will be turned over to our collection agency.

SELF-PAY PATIENTS: **Payment is due at the time of service.**

NON-SUFFICIENT FUNDS/RETURNED CHECKS: $45 will be charged for any returned checks and a different form of payment will be expected for past balances and future services rendered.

DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS: The parent who brings the minor child to therapy is responsible for payment of services rendered. Hand Therapy Associates will not be involved with separation/divorce disputes.

TREATMENT RELEASE and HIPAA CONSENT FORM: I understand that the therapeutic treatment that I am about to undergo may have the potential for resulting in any of the following complications. Though I am not fully versed in the medical implications of these conditions, at least I am aware of them as potential hazards. These situations would include:

*Stiffness (loss of motion/painful motion)	*Arthritic inflammation	*Loss of motion
*Failure of therapeutic procedures	*Inordinate swelling	*Potential burns
*Complications of modalities	*Pain	*Additional fees

*Variation of functional status of nerves, arteries, veins, bones, joints, muscles, tendons, ligaments, nails/nail beds and their environs (permanent damage to any or all of these structures). I am also aware that as a therapeutic environment there are tools and equipment that may result in injury if misused.

I hereby request, authorize and give my consent to Hand Therapy Associates PC to perform whatever therapy procedure, treatment or technical procedure they deem necessary and advisable in the diagnosis or treatment of my case. This therapeutic procedure(s) and any ongoing subsequent procedure(s) throughout the course of my treatment of which I am about to undergo has been explained to me in detail, and I understand in general what is to be done, and there are certain calculated risks to be taken, and that Hand Therapy Associates, PC has made no guarantee to me whatsoever. I understand that the therapeutic procedure(s) that I am about to undergo has been authorized and prescribed by my referring physician.

I hereby authorize Hand Therapy Associates, PC to release any information as it pertains to my diagnosis to any doctor, therapist, insurance institution or financial institution. This authorization also constitutes my permission for employees of Hand Therapy Associates, PC to speak to any of the above parties. I hereby release Hand Therapy Associates, PC and its employees from any responsibility for the disclosure of said information.

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I understand that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

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PRINT NAME RELATIONSHIP TO PATIENT

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SIGNATURE DATE