

**COLORADO HAND THERAPY, LLC
FINANCIAL POLICY**

Name *(Last, First, I.):* _____

Date: _____

Thank you for choosing Colorado Hand Therapy as your therapy provider. Our office will file all primary claims directly to your insurance carrier unless you request otherwise. If you do not have insurance, payment is due at the time of service. If you are unable to make payment in full you will be required to contact our office and establish a payment schedule before continuing your therapy.

CANCELLATION AND NO-SHOW POLICY

Failure to provide twenty-four (24) hours advance notice will result in a \$40.00 charge being added to your account. These charges will not be billed to your insurance carrier and will be due at your next therapy visit. Cancellation or failure to attend three consecutive appointments will result in termination of your therapy program. To restart your therapy, you must return to your physician for a new prescription and obtain additional authorization from your insurance carrier. **INITIAL:** _____

PREAUTHORIZATION AND REFERRALS

You are responsible for obtaining preauthorization or physician referrals for your care. Any care denied for lack of authorization, referral or lack of information will be your responsibility. You are also responsible for contacting your insurance company to verify coverage and limitations for your therapy. Charges denied as "not a covered benefit" are your responsibility. Verification of benefits does not guarantee payment. It is your responsibility to insure that you understand the limitations of your benefit plan before continuing your treatment. In the event that Colorado Hand Therapy bills your insurance with no response, it will your responsibility to contact your insurance company. **INITIALS:** _____

MEDICARE PATIENTS

Our office is an approved participating Medicare provider and we will bill Medicare directly. Secondary insurance will be filed for you if you have provided all necessary information. Splints and other supplies are not always a covered benefit under the Medicare plan. Many supplemental insurance policies do not cover charges denied by Medicare. You are responsible for charges according to your Part-B coverage including deductible and coinsurance amounts.

PLEASE NOTIFY US IMMEDIATELY OF ANY OF THE FOLLOWING:

- **Have you enrolled in a Medicare HMO?** Yes No
- **Have you elected Hospice or Home Health?** Yes No

WORKER'S COMPENSATION PATIENTS

We can not bill your worker's compensation insurance without verification of your injury from your employer. We require billing address, claim number and the name and telephone number of your adjuster. In the event that our office is unable to verify and authorize your treatment, you are financially responsible for your charges. In the event of a denial, our office will attempt to file your charges, the balance will become your responsibility. **INITIAL:** _____

AUTOMOBILE and THIRD PARTY LIABILITY

Colorado Hand Therapy does not accept any third party liability, including liens from an attorney. If you were injured in an automobile accident and your automobile insurance carrier cannot guarantee payment of services or you are unable to obtain authorization from your health insurance, you will be required to pay at the time of service. Please be aware you are responsible for any unpaid balance regardless of your insurance company's determination. **INITIAL:** _____

I have read and understand the Financial Policy and I am aware that a copy of this policy is available to me upon request.

Signature: _____

Date: _____

Responsible party if under 18: _____

Date: _____