# ORTHOPTIC REHAB CLINIC OF METAIRIE

RAP MBM

Please answer all questions to the best of your ability:

**Patient's Name:** _____**DATE OF BIRTH:**

_____/_____/_____ Address_____ City_____

State_____ Zip_____ **Email** _____Social

Security#_____ Home#(_____)_____ Cell#(_____)_____

Sex: **M F** Marital Status: **S M W D**

*Have you received **P.T. or Home Health Care** for this calendar year***? Circle:** Yes / No **IF YES:**

*Facility Name:*_____ *DISCHARGED Date*: _____/_____/_____

**Employer** _____ **Occupation**_____ Ph#_____

Emergency Contact_____ Relationship _____ **Ph#**_____

**Referring Physician**_____ **Injury or Surgery Date:** _____/_____/_____

**ATTORNEYREPRESENTING YOUR CLAIMS: Yes_____ No _____** If yes:

***Attorney Name:**_____ **Ph#**_____

| **Primary Insurance/ Responsible Party** | **Secondary Insurance/ Other** |
|---|---|
| **Name of Ins. Co.:**_____ | **Name of Ins. Co.:**_____ |
| **Policy Holder Name:** _____ | **Policy Holder Name:** _____ |
| **DOB:**_____/_____/_____ | **DOB:**_____/_____/_____ |
| Addtil Info: | Addtil Info: |

I acknowledge that the above information is true and correct. I hereby authorize treatment and understand the possible benefits and risks of my treatment. I know and agree that OrthoPTic Rehab Clinic of Metairie is not responsible for loss or damage to personal items. I irrevocably assign all benefits directly to OrthoPTic Rehab Clinic of Metairie. I authorize the release of any medical records necessary to process medical claims. I understand fully that I am responsible for all amounts not covered by my insurance. I understand that I must notify OrthoPTic Rehab Clinic of Metairie any changes in insurance/payer information immediately to avoid delays in the processing of claims. I understand that if my insurance fails to pay for my services, I will be responsible for payment in full within 30 days of notification. I agree to pay all co-payments and/or my financial responsibilities at the time services are rendered.

_____

**Patient's Signature** (parent if minor) Date

_____

Clinic Representative Date

**PLEASE TURN OVER**

# ORTHOPTIC REHAB CLINIC OF METAIRIE
# FINANCIAL POLICY

**TO OUR VALUED PATIENTS:**
We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

We accept cash, checks, Discover, MasterCard, or Visa. We bill electronically, to expedite payment of claims. If you have an insurance that requires a paper claim to be completed, we will gladly mail this claim for you.

Please read carefully:

1. **PAYMENTS**- Co-payments and payment for services are due at each visit or at the end of your treating week. If you have a deductible or coinsurance, we can estimate your responsibility to be paid on each visit and you will be billed once all claims have processed.

2. **IN NETWORK/OUT OF NETWORK**-Your insurance is a contract between you, your employer and your insurance co. We are a participating provider for most insurance companies. If we are in network, we will charge you no more than our contractual rate with your insurance company if applicable. If we are out of network with your insurance company and your claims are submitted to your insurance company, you will be responsible for all reasonable and customary charges as indicated on the explanation of benefits received from your insurance company. For more clarification on this, please speak with our Insurance Manager.

3. **BENEFIT LIMITS**- Some insurance plans have a financial or visit limit for physical therapy services. It is ultimately your responsibility to know your benefit limits. We have procedures in place to help you stay within any limits, and will obtain these benefits for you. You will be responsible for charges not paid by your insurance company due to the exhaustion of your benefits and/or termination of coverage.

4. **WORKERS COMPENSATION**-If your injury is work related, and a Workers Compensation claim has been initiated, you or the referring physician must provide our office with your claim number, adjuster's name and phone number before your initial visit. We must need authorization/approval BEFORE your initial evaluation is scheduled. Please be advised that if your account is not paid by your comp. carrier, you will be responsible for all charges within 30 days of notification.

5. **ATTORNEY CASES**- It is this office's policy that a letter of guarantee and a $500 deposit must be received from your attorney before the first visit. Without this letter and deposit, you will be responsible for the account in full.

6. **AGREEMENT TO PAY-** In the event your insurance company forwards payment directly to you, you will be responsible for delivering said payment to OrthoPTic Rehab Clinic of Metairie within 15 days of payment. Should you choose to file your own insurance claims, our billing manager can provide you an itemized statement of services rendered, however payment will be required in full at the end of each visit.

Our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Failure to comply with these guidelines will result in placing your account with a collection agency.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you!

I have read the above policies and agree.

**SIGNATURE:**_____ **DATE:** _____

## PLEASE TURN OVER