HUDSON VALLEY ORTHOPAEDIC & SPORTS PHYSICAL THERAPY
PAYMENT AGREEMENT

 Hudson Valley Orthopaedic & Sports Physical Therapy is committed to provide you with the best possible care and to obtain, on your behalf the maximum allowable benefits from your insurance carrier toward the charges for your physical therapy treatments. Please read the highlighted sections below that pertain to your treatment and insurance coverage. If you have any questions, please do not hesitate to ask our staff.

 REFERRALS: New York State law requires all patients treated by a physical therapist must be referred by a medical doctor, dentist, podiatrist, physician assistant or nurse practitioner. The referral and /or prescription must be currently dated and in writing. A return visit or call to your referring physician may be required if your therapy is to continue beyond your written prescription. Please discuss your condition with your physical therapist and inform the therapist and/or desk staff of any scheduled appointments with your referring physician.

 AETNA , EMPIRE BLUE CROSS/BLUE SHIELD, CDPHP, CIGNA, GHI HMO, HEALTH NET, HUDSON HEALTH PLAN, MAGNACARE, MULTIPLAN, MVP, NHAI, Inc., OXFORD, POMCO, UNIFORMED SERVICES FAMILY HEALTH PLAN (USFHP), UNITED HEALTHCARE, 1199 SEIU BENEFIT PLAN, and the NYS EMPLOYEE BENEFIT PLANS (EMPIRE PLAN, INDECS, Etc.): This office is a participating provider for **most** of the benefit plans offered by the above carriers. Your physical therapy benefits for any of the above insurers are determined by the plan to which you have subscribed or been assigned. Please contact your insurance benefit department if you are uncertain of your physical therapy coverage.
Your coverage may require pre-certification, an authorization or a referral number prior to your initial visit. Additionally, your plan may limit the number of visits allowed for your diagnosis regardless of the number of visits written on the prescription from your physician. It may be necessary for your physical therapist to request authorization for all visits beyond the initial evaluation if a management company has been hired by your insurance to monitor your progress.
The charges for each physical therapy visit are subject to either our contract rate with your insurance carrier or may vary depending upon the treatment received during any given visit. We request that any per visit co-payments, coinsurance and items purchased (which will not be reimbursed by your insurance) be paid at the time of service. You will be advised of any deductible amount due when we receive this information from your insurance company.

 PRIVATE INSURANCE: If you have insurance coverage for physical therapy, we will submit all charges to your carrier on your behalf. If you are uncertain of the limits of your physical therapy coverage, please contact the benefit department of your insurance to clarify your policy's allowable reimbursement. **The charge for each physical therapy visit will vary depending on the treatments you receive during any given visit.** Most major medical polices reimburse 80% of our charges. **We request that you pay $15.00 per visit on a weekly basis, in addition to any applicable deductible and for items purchased which will not be reimbursed by your insurance.** If your insurance reimbursement is less than 80%, we reserve the right to bill you for any remaining balance, up to the 80% of the total charges plus your $15.00 per visit co-payment.
Example: Charge = $100.00, insurance pays 80% = $80.00 + patient paid $15.00 = $95.00 - accepted as payment in full.
Charge = $100.00, insurance pays 70% = $70.00 + patient paid $15.00 = $85.00 - patient owes $10.00.

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 Please print the information requested on both sides of this form and return it along with your insurance cards to the front desk. Thank you.

Date: ______________________

Patient Name: ____
first middle last

Policy Holder's Name: ____
first middle last

Policy Holder's Address: ____
street city state zip code

Policy Holder's Employer: ____

Policy Holder's relationship to the patient: _______________ **Policy Holder's sex: Male____ Female ____**

Primary Insurance Company Name: ____________________________________

Billing Address: ____
Street/P.O. Box city state zip code

Phone Number: ______________________________

Insurance / Member ID #: ________________________ Group #: ___________________________ **(Continued on reverse side)**

□ **Is the patient's condition related to:**

- □ **Employment (current or previous)? Yes____ No____**
- □ **Automobile accident? Yes____ No____**
- □ **Other accident? Yes____ No____**

□ **HAVE YOU RECEIVED PHYSICAL, OCCUPATIONAL OR SPEECH THERAPY OR ANY CHIROPRACTIC TREATAMENT THIS YEAR? If yes, where, when, and for what condition ____**

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□ **Does the patient have any other medical insurance? Yes____ No_____**

□ **If yes, please complete the following:**

Policy Holder's Name: ____
first middle last

Policy Holder's Address: ____
Street city state zip code

Policy Holder's Employer: ____

Policy Holder's relationship to the patient: _______________ Policy Holder's sex: Male____ Female ____

Secondary Insurance Company Name: ____

Billing Address: ____
Street/P.O. Box city state zip code

Phone Number: _____________________________

Insurance / Member ID #: ________________________ Group #: ___________________________

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- □ **I agree to pay weekly any portion of my bill that my insurance will not reimburse directly to Hudson Valley Orthopaedic & Sports Physical Therapy.**
- □ **I understand I am financially responsible for payment in full, if for any reason my insurance does not cover the charges for my physical therapy treatment as outlined in this payment agreement.**
- □ **If my account is forwarded to a collection agency as a result of non-payment, I will also be responsible for any fee the collection agency imposes on my account.**
- □ **I will notify the office staff if temporary financial problems arise that may affect my account, in an effort to make arrangements agreeable to all parties.**

□ **Patient Signature: ____**

□ **Parent or Legal Guardian Name: ____**
(Please Print) first middle last

□ **Parent or Legal Guardian Signature: ____**

□ **Relationship to patient: ______________________________**

REVISED 04/2014