The Center For
BODIES IN BALANCE

1 GREENLEAF WOODS DR, STE 101, PORTSMOUTH, NH 03801
P: 603 / 319-8334 F: 603 / 431-2940

FINANCIAL POLICIES

PROOF OF INSURANCE: All patients must provide valid and up-to-date proof of insurance coverage. If you provide false or expired insurance information you will be responsible for the balance of the claim. Please notify us of any changes in insurance coverage prior to time of service. **Insurance denials for termination of coverage, incorrect PCP, or other misinformation will be automatically billed to you.**

KNOW YOUR INSURANCE BENEFITS: The Center for Bodies in Balance (CBB) participates in most HMO and PPO plans, as well as Medicare. Keep in mind that your insurance policy is basically a contract between you and your insurance company. We will bill your insurance as a courtesy to you. **Please call your insurance company to confirm your coverage. Knowing your insurance benefits is your responsibility.** If you change insurance coverage while undergoing treatment, or if your benefits change with your current policy, it is your responsibility to notify the office of this change. You will be responsible for any balance due to faulty insurance information or lack of notification regarding changes. After the insurance company pays their portion, you are responsible for the balance, including deductibles. Secondary insurance claim submission is typically the patient's responsibility.

SELF PAYMENT: We recognize that some of our patients may be without insurance, or have insurance that CBB does not participate with. For self-pay patients, the payments are expected in full at the time of the service. We offer a discount only on the day of service, providing there is no balance outstanding.

WORKERS' COMPENSATION CLAIMS, AUTO INSURANCE AND THIRD PARTY LIABILITY CASES. We are required by law to file claims related to any injury incurred at work. In order for a claim to be considered work-related, you must report the incident to your employer. We require that you supply us with the Worker's Comp claim number, phone number, contact person and the name and billing address of the Worker's Comp carrier at the time of the appointment. If you claim Workers' Comp benefits and are subsequently denied such benefits, you will be held responsible for the total amount of charges for services rendered. For other third party liability insurance (such as auto insurance), please inquire.

CANCELLATION, NO-SHOW, LATE ARRIVALS: Our physical therapists are scheduled for a full 45 or 60 minutes to spend one-on-one time with their patients. This time has been reserved for you. **Therefore, we require 24 hour notice in the event of a cancellation (Monday appointment requires a call on Friday). The charge for cancellation without proper notice is $50.00 (effective 08/01/16) for a physical therapy visit.** This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment. Also, to insure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality, it is very important for each scheduled patient to arrive for their visit on time**, if you arrive more than fifteen minutes late for your appointment, you may be asked to reschedule and pay a cancellation fee.** Of course, there are exceptions in the event of illness or emergency.

CO-PAYMENTS: Co-payments are due at the time of service. **At this time we accept cash, check and major credit cards. Some HSA cards currently do not process with our processing system. Most HSAs will provide you with a checkbook when requested. Upon request an itemized receipt can be provided to you for HSA reimbursement.** We normally don't bill for copays, but expect our patients to keep current with each visit, or every 2 or 3 visits.

CO-INSURANCE AND DEDUCTIBLES: After filing with your insurance company, CBB will mail you a balance statement. Payment in full is expected within 30 days after receipt of this statement. If you have questions, or dispute the amount, please call our office at 603-319-8334. If you need to set up a payment plan (only in the case of deductible balances), please contact the office immediately. If formal collections procedures become necessary you will be responsible for additional costs incurred.

Checks returned for Non-Sufficient Funds are subject to a $25 processing fee.

I hereby authorize The Center for Bodies in Balance to furnish information to my insurance company concerning evaluation and treatments and I hereby assign to CBB all insurance benefits for medical services rendered. I understand and agree that (regardless of insurance status) I am ultimately responsible for any and all professional services rendered. I have read the information in this financial policy and I understand all its terms.

PRINT PATIENT NAME _____ DATE OF BIRTH _____

PATIENT (PARENT/GUARDIAN) SIGNATURE _____ DATE _____

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CONSENT/PRIVACY NOTICE/COMMUNICATION PREFERENCES

CONSENT FOR CARE & TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment plan will be designed. A variety of techniques may be used. I, the undersigned, do hereby agree and give my consent for The Center for Bodies in Balance, LLC, to furnish physical therapy care and treatment considered necessary and proper in evaluating and/or treating my physical condition.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize The Center for Bodies in Balance, LLC, to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

NOTICE OF PRIVACY PRACTICES: In compliance with the Federal Law regarding patient's privacy, we ask you to read the "Notice of Privacy Practices", that is available to view at the office. I understand that I have been provided the opportunity to review this document prior to signing this consent, and that a written copy will be provided upon request.

COMMUNICATION PREFERENCES: Mark an "X" for your choice.

Best way to reach you on the day of your appointment in case we have to change or cancel your appointment?
Call Cell ____ Text Cell _____ Call Home _____ Call Work ____

Can we leave messages on your cell phone or home phone? Yes ____ No _____

Can you receive text messages? Yes ___ No ___

Do you check your email? Yes ___ No ___
If so, can we send appointment confirmations via email Yes ___ No ___

CONSENT FOR TREATMENT OF A MINOR: A parent/guardian must accompany a minor patient on all of the office visits, unless written consent of the parent or legal guardian is received.

As parent and/or legal guardian, I authorize The Center for Bodies in Balance, LLC, to treat
_____ (minor's name) while I am not present.

ALL Patients Sign Below to Acknowledge Their Understanding of the Above

_____ _____
SIGNATURE OF PATIENT/GUARDIAN/RESPONSIBLE PARTY DATE

_____
PRINT NAME

OVER