ADVANTAGE PHYSICAL MEDICINE & REHAB
60 DUNNING ROAD, SUITE 1
MIDDLETOWN, NY 10940-2216

P: 845-344-4477 F: 845-344-6072

Financial Policy

Patients have many different types of insurance and payment options for services rendered. Note, not all physicians in the practice accept the same type of insurance. To ensure that we have accurate information to process your claim, we will make a copy of your medical insurance and/or Medicare card at the time of your appointment.

You are required to inform us immediately of any changes in demographic information or medical insurance information. Patients without medical insurance are required to pay in full at time of service.

We understand that financial hardships may affect your ability to pay in full. We will always do everything we can to work with you. Please ask to speak to our biller to discuss a satisfactory arrangement.

Participating Plans:
You must present your insurance card, and if applicable, your insurance referral form, at every visit. We will submit bills directly to your insurance company for payment on your behalf. Patients without insurance cards or proper referrals will be asked for full payment at time of service. All co-pays, deductibles and non-covered services will be collected at time of service.

Non-Participating Plans:
If rendering provider does not participate in your insurance plan, you are responsible for payment of all charges at the time of service.

Cancellation/No Show Policy:
As a courtesy, confirmation calls will be made to the patient prior to his/her scheduled appointment date and time. For New Patient and EMG visits, patient needs to confirm with the office 48 hours prior to the scheduled appointment time - If the office does not receive confirmation, your appointment may be cancelled and future appointments will not be made. For all other visits including physical therapy, patient is encouraged to confirm with the office 24 hours prior to the schedule appointment time. The charge for a Late Cancellation/No Show is $35.00 which is to be paid prior to rescheduling another appointment.

Telehealth Policy:
Telehealth visits are considered the same as an office visit. If you are scheduled for a VIDEO visit, you must be in a place where the visit can take place. The doctors will NOT conduct the visit if patient is driving/in public etc. This will be considered a LATE CANCELLATION and you will be charge a late cancellation fee. If you are scheduled for a PHONE visit, your doctor will call you at the designated phone number left at the time of scheduling. If you are unavailable at the time your doctor contacts you, this will be considered a NO SHOW and will be charged a no show fee.

If you do need to cancel or reschedule, please notify our staff as soon as possible. If all patients do this, it enables us to better accommodate patients in a timely manner. It is very important that you confirm your appointment and/or call in advance to cancel your appointment. If you fail to notify our office in time, your account will be charged accordingly.

Patient Signature________________________________Date___________________

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HIPAA Privacy Authorization Form

I ______________________________ authorize Advantage Physical Medicine & Rehabilitation to use and disclose the protected health information as described below. By signing this form I understand :

- My protected health information may be used or disclosed by the practice for treatment, payment or healthcare operations as allowed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- I have a right to restrict the use of the protected health information but the practice does not have to agree to those restrictions if information is needed to treat the patient, bill for services, comply with the law, etc.
- Any changes to my consent to the disclosure of my protected health information must be done by me in writing. The change will take effect on the date I provide the updated form with my signature and does not effect disclosures that may have occurred before the update.
- This consent will expire 1 year from the date below. I will be asked for an updated signature and will have the opportunity to make changes to my consent at that time.

Please read the following statements carefully and answer YES or NO.

I give the practice permission to leave voicemails on my home/cell/work (circle)	Yes	No
I give the practice permission to send information to me via secure email when requested.	Yes	No
I give the practice permission to speak to specific people about my appointments (time, date, location, physician etc)	Yes	No
I give the practice permission to speak to specific people about my care/treatment	Yes	No
I give the practice permission to speak to specific people about financial/billing information including statements/ balances/ and copayments	Yes	No

We will only speak to the patient unless otherwise specified. Please provide the name(s) for any person(s) that the practice is allowed to speak to on your behalf. <u>If you do not wish to have us contact or speak with anyone else but you, leave this area blank.</u>

Name: ___________________________________ Relationship: ____________________________

Name: ___________________________________ Relationship: ____________________________

Name: ___________________________________ Relationship: _____________________________

By signing this form I agree to authorize Advantage Physical Medicine and Rehabilitation to disclose my protected health information as allowed by HIPAA or otherwise described above.

Signature: ____ Date: ______/_____/_____