Financial Policy

1. **Payment** is expected **at the time of your visit**. We will accept cash, check, or credit card. We do require a form of ID at the time of your first visit due to the many cases of identity theft in the news lately. (Please do not be offended). We only keep $50 of change on hand daily, so please bring appropriate cash amounts if you choose to pay that way. _____(Initial)
2. **Insurance.** We are currently out of network (OON) with select insurance companies (please speak to a representative to inquire if your insurance is in network or not) **Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full**. We will submit claims to all insurance companies with the exception of Aetna. Any claims not paid to the practice within 60 days will be billed to the patient and payment is expected within 5 days or the CC on file will be charged. In Many cases with OON Benefits, the patient will be paid directly, so any refunds due will be paid quarterly. **Any pre-authorization process that needs to be completed before your appointment is the responsibility of the patient.** _____(Initial)
3. **Assignment of Insurance Benefits for In-Network.** (Medicare, Medicaid, & Cigna) I hereby assign, transfer, and set over directly to APTaSM sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to me or my dependent in said clinic. I authorize APTaSM to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to APTaSM. I authorize APTaSM to release all medical information (including, but not limited to: information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, or other physicians or providers, and any other third-party payers._____(Initial)
4. **Returned Checks** will incur a $40.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $40 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $40 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Arapahoe County._____(Initial)
5. **Forms Fees.** Completing insurance forms, copying medical records, etc. requires office staff time away from patient care for our Doctors. We require pre-payment for completing forms, copying medical records, or for communication. Base form charges are $10 per occurrence plus an applicable postage or notary fees. Postage is additional and payment is required in advance. Copying fees for medical records when requested by the patient are as follows: $14.50 for the first 10 pages. $0.50 per pages 11-40, and $0.33 per pages 41 and up. We have 15 days to make said copies and these 15 days will commence after payment for copying has been received and after the patient has signed this form authorizing records release. 3rd parties requesting copies have a different fee and you can find that at Health Facilities and Emergency Medical Services Division website._____(Initial)
6. **Cancellations or Missed Appointments.** You are the most pivotal piece of getting better, but like all other health issues, you need a coach. We schedule time to spend with just you in this clinic. We don't book you with an aide or PTA. If you miss that time, it takes away from another person we could be helping get back to their life. Therefore if you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $100 fee if we are participating with your insurance, or the cost of the appointment if you are part

of our concierge package. Tardiness to your appointment may (at the discretion of the provider) be counted as a no-show. Tardiness is defined as being 5 or more minutes late to any scheduled appointment._____(Initial)

7. **Accounting Principals.** Payment and credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding dates of service._____(Initial)
8. **Responsibility for Payment.** You, as the patient, understand that you personally are financially responsible to Agility Physical Therapy and Sports Medicine for charges not covered by your insurance company for any reason._____(Initial)
9. **Statement Late Charges** of 22% annually will be applied to all patient balances 60 days or older._____(Initial)
10. **Collection Fees.** I understand that in the event my account is placed in collection status, and additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, no-shows or late cancellations, collection agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full._____(Initial)
11. **Divorced Parents of Patients.** By signing below, the adult who signs a minor child into our practice on the first day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues._____(Initial)

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of patient (or guarantor, if applicable) Date

_____ _____

Printed of patient (or guarantor, if applicable)

Agility Physical Therapy and Sports Medicine

Credit Card Authorization Form

I, _____ (print name), authorize Agility Physical Therapy and Sports Medicine, to charge the card I gave to be on file, for agreed upon purchases.

No shows, late cancellations, or any Cryoskin© products, cannot be charged to any Health Savings Account cards.

You may cancel this authorization at any time by contacting us.
This authorization will remain in effect until cancelled.
We require all cards to be on file for the remainder of your care.

_____ (initials) I understand that my information will be saved to file for future transactions on my account. Failure to pay a bill within 15 days of a statement will result in an automatic charge to the card on file. As a small practice, we can no longer accept other forms of payment due to a high volume of lack of payment in the past. We require every patient to have a card on file through our very secure network to ensure that we have payment in a timely manner. If you absolutely do not wish for your card to be on file, or prefer to pay by check, then the package that you have selected will need to be paid 100% up front to ensure we have full payment for services rendered.

_____ _____

Client Signature Date

Physical Therapy Consent

1. I _____(patient's printed name) give permission for APTaSM to provide evaluation, diagnosis, and treatment for my current injuries/ailments.

2. _____ (initials) I understand that I play a pivotal role in my healing process and i must do the exercises and home programs that are provided by my care provider. I must also attend all scheduled appointments at my scheduled time (or give 48 hours notice of a cancellation or date change) or incur a $100 fee if APTaSM is participating with my insurance company, or the cost of my appointment if I am a part of a packaged care plan (please see a representative for our packages), that will be charged to the card I have given APTaSM to have on file for me.

3. _____ (initials) (If APTaSM is participating with my insurance ONLY) I understand that I am responsible for my portion of deductibles, copays or coinsurance that I am responsible for. I will pay in a timely manner or be subject to interest charges and collection fees. I also understand that in the event my insurance company takes longer than 60 days to pay, I will be billed the cost of the appointment according to the amount of time spent with me. I hereby agree to pay all collection fees and attorney fees in the event that my account is assigned to collections to enforce payment of this debt.

4. _____ (initials) I understand that if I have a check returned, I will be responsible for any blank charges and a $40 fee for service and no longer allowed to pay by check.

5. _____ (initials) I understand that I have a right to refuse billing my insurance company and pay a cash rate pay for any of the packages provided to me (please see a representative for more details on packages and package pricing). I also understand, that packages expire 100 days (with the exception of packages that will take more than 100 days to administer) from the initial purchase date.

6. _____ (initials) I understand that I have the right to refuse any specific types of treatment and agree to communicate with my care provider those desires.

7. _____ (initials) I give APTaSM permission to contact any of my other care providers regarding my injuries and obtain prior medical records so that the best care possible may be provided for me by my Physical Therapist.

8. _____ (initials) I give permission to leave messages from APTaSM on any of the following:
    a. Home Phone Number: _____
    b. Cell Phone Number: _____
    c. Emergency Contact (name and phone number): _____
    _____

Patient Printed Name: _____

Patient Signature: _____ **Date:** _____

Surprise/Balance Billing Disclosure Form

Surprise Billing – Know Your Rights

Beginning January 1, 2020, Colorado state law protects you* from "surprise billing," also known as "balance billing." These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or
- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado

What is surprise/balance billing, and when does it happen?

If you are seen by a health care provider or use services in a facility or agency that is not in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of-network health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

If you are receiving emergency services, the most you can be billed for is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility where you receive emergency services and any providers that see you for emergency care.

Non Emergency Services at an In-Network or Out-of-Network Healthcare Provider

The health care provider must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. They must also tell you what types of services that you will be using may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for **covered** services is your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. These providers cannot balance bill you for additional costs.

Additional Protections

- Your insurer will pay out-of-network providers and facilities directly.
- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.
- Your provider, facility, hospital, or agency must refund any amount you overpay within sixty days of being notified.
- No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

If you receive services from an out-of-network provider or facility or agency OTHER situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed.

If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website: https://www.colorado.gov/pacific/dora/DPO_File_Complaint.

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact the billing department, or the Colorado Division of Insurance at 303-894-7490 or 1-800-930-3745.

*This law does NOT apply to ALL Colorado health plans. It only applies if you have a "CO-DOI" on your health insurance ID card.

Please contact your health insurance plan at the number on your health insurance ID card or the Colorado Division of Insurance with questions.

Disclosure of Out Of Network Status:

Agility Physical Therapy and Sports Medicine, LLC and 5280 Restorative Medicine are Out Of Network Providers for Most major insurance companies. While we will submit billing to Medicare, Medicaid, Tricare and Veterans, All other responsibility to submit a claim is that of the patient. You may engage your insurance company by calling and asking for a patient advocate to send all of your claims directly to, or they may have an online portal in which you can submit. Your Payment is Due Upon your Visit. We WILL NOT BALANCE BILL. If you are due a refund because your insurance company has chosen to pay us directly, instead of to you, It will be done at the end of each fiscal quarter.

_____

Patient Signature

_____

Patient Name

_____

Date