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REHABILITATION AND HEALTH SCIENCE, LLC

FINANCIAL POLICY

Medical Insurances:
We participate with and bill the following insurances, most plans: Aetna, Anthem, Cigna, Harvard Pilgrim, HealthPlans Inc, Humana, Medicare, NH Medicaid, Martin's Point, Private HealthCare System, Tricare, Tufts, Choice Care Network and United HealthCare . Please check with your insurance to make sure we are an In Network provider with your specific policy.

Please provide us with ALL of your information if you have multiple policies. (E.g. Medicare and Medigap) We will file supplemental or secondary insurances when appropriate.
We will make a reasonable effort to bill other insurance companies; however, there may not be any benefits or limited benefits for services provided by our therapists. You must obtain all necessary referrals and/or prescriptions before beginning Physical Therapy. ***Please be advised that it is your responsibility to contact your insurance company to determine your coverage prior to treatment.***

Managed Care Insurances & Referrals
Our therapists may not be authorized to provide service for patients with managed care insurance without a referral from a primary care physician. Please contact your primary care physician for a referral authorization. If you do not have an authorization prior to your appointment, you will be asked to sign a waiver accepting responsibility for payment should authorization be denied.

Understanding your insurance coverage:
We will do our best to help you understand your benefits. If you have any questions about your health insurance in regards to coverage for physical therapy services, please call us at (603) 890-8844.

Payment at Time of Service:
If you have no medical insurance, payment in full is expected at the time of service. **Co-payments co-insurances and deductible amounts are due at the time of service.** Patients with previous uncollectible balances are expected to pay before the provision of services. **We accept cash, checks, debit cards, and most credit cards.**

Minors:
It is our policy that the individual who brings a child/minor into our offices and consents to treatment for services is accepting full responsibility for any balance due for services rendered.

I authorize assignment of insurance benefits to Balance Physical Therapy, LLC for the purpose of payment towards services rendered by Balance Physical Therapy, LLC.

I understand and agree that regardless of my insurance status, I am ultimately responsible for my account for any professional services rendered by Balance Physical Therapy, LLC.

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EFFECTIVE 10-20-2021

Balance Physical Therapy Scheduling Policy

PLEASE GIVE US AT LEAST 24 HOURS NOTICE FOR CANCELLATION OR RESCHEDULING

In an instance of a cancellation without 24 hours' notice or a no-show to a scheduled appointment, **YOU WILL BE CHARGED A $50 FEE.** Exceptions may be made in the case of an emergency, illness, or inclement weather. Please note that this charge cannot be billed to insurance and must be paid on or before the next scheduled appointment. **If you no-show or cancel more than 3 appointments without at least 24 hours notice, your therapy with our team will be discontinued.**

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We do our best to schedule your appointments at convenient times so that you will receive consistent and effective physical therapy. We try to accommodate the scheduling needs of all of our patients. In consideration to our physical therapists, staff and all of our patients here at Balance Physical Therapy, we respectfully request the following:

- **PLEASE SCHEDULE APPOINTMENTS AS FAR IN ADVANCE AS POSSIBLE**
  This is especially beneficial if your availability is limited to particular times in the day or particular days of the week. Our busiest times are early in the morning and mid-to-late afternoons. Booking in advance will increase the likelihood of getting the most convenient time for you.

- **PLEASE BE TIMELY FOR YOUR APPOINTMENTS**
  If you arrive more than 15 minutes late for your scheduled appointment, you may have to be rescheduled. This is for the benefit of you and other patients being treated.

- **PLEASE GIVE US AT LEAST 24 HOURS NOTICE FOR CANCELLATION OR RESCHEDULING**
  In an instance of a cancellation without 24 hours' notice or a no-show to a scheduled appointment, **YOU WILL BE CHARGED A $50 FEE**. Exceptions may be made in the case of an emergency, illness, or inclement weather. Please note that this charge cannot be billed to insurance and must be paid on or before the next scheduled appointment. **If you no-show or cancel more than 3 appointments without at least 24 hours notice, your therapy with our team will be discontinued.**

- **FITNESS/PERSONAL TRAINING CLIENTS**
  The missed appointment fee is the cost of one of your sessions.

Signing below indicates that you understand and agree to the terms of these policies.

Signed: ____ Date:______________

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to:

- Ensure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you;
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following describes different ways that we are permitted to use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use and disclose your medical information to make a decision about and plan for your care and treatment. This may include consulting with other health care providers during the course of your treatment.

For Payment. We may use and disclose your medical information so that the treatment and services you receive at the clinic may be billed and payment may be collected from you, an insurance company, or a third party.

Determine Eligibility for Insurance Coverage: We may tell your health plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment.

Other Purposes: We may use and disclose your medical information to perform various office, administrative and business functions that support the clinic’s ability to provide you with appropriate care.

As Required By Law. We will disclose your medical information when required to do so by federal, state or local law.

Workers' Compensation. We may release your medical information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

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YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Obtain a Copy. You have the right to inspect and obtain a copy of your medical information that may be used to make decisions about your care.

Right to Amend. If you think that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by or for the clinic. Please note that no part of the original documentation in the medical record can be destroyed.

Right to Request an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of your medical information for which an authorization was not obtained, or which were not made for purposes of treatment, payment, or healthcare operations.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend.

We are not required to agree to your request for restrictions. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment to you.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only at work or by mail.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us at any time to give you a copy of this notice.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with the Clinic or with the Secretary of the Department of Health and Human Services. You may file a complaint with the Clinic by speaking with any of the Staff and requesting a HIPAA complaint form.

You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Changes to this Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the clinic. The notice will contain the effective date on the first page, in the top right-hand corner.

I have read and agree to the information given to me above.

Signed:____ Date:_______________

Parent/Guardian:____ Date:_______________

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