THE MOVEMENT CLINIC

Payment Agreement

Thank you for choosing The Movement Clinic, LLC as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

- **In-Network Policy.** We are committed to providing you with the best possible care, and will help you receive your maximum allowable insurance benefits. We need your assistance and your understanding of our payment policy. Your insurance contract is between you, your employer and the insurance company. Not all services are covered by all contracts. While the filing of insurance claims for participating insurance carriers is a contractual obligation of the practice, all fees are ultimately the patient's responsibility. We will be happy to help you process your insurance claim form for reimbursement. For Medicare assignment and participating insurance plans, covered charges will be paid directly to us. We file to participating secondary payers one time only. If payment is not received within 45 days, we will send you a statement and payment will be expected at that time. This office cannot accept responsibility for negotiating a settlement on a disputed claim. If we do not participate in your insurance plan, you may still choose to be seen by the practice. We will require payment in full at the time services are rendered. As a courtesy to you, we will provide you with the documentation necessary for you to file with your insurance carrier on your own behalf.
- Required insurance referral forms must be complete, current and presented at time of service. If you arrive for your appointment without valid, current insurance identification or a required referral, we will offer you the option of rescheduling your visit or making payment in full at the time services are rendered. All patients are encouraged to submit photo identification at the time of registration to enable our office to reduce the incidence of identity theft. We accept cash or checks, Visa, MasterCard, Discover or American Express. A fee of $35.00 will be charged for checks returned for insufficient funds or any other reason, whether issued directly by the patient or on the patient's behalf.
- *We will estimate and collect patient balances, including co-payments, co-insurance and deductibles, on the day of the visit but will wait for the claim to be processed by the insurance plan, as applicable, before collecting the full amount due.*
- You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
- Payment is expected at time of service unless you have made other payment arrangements with us.
- **Out-of-Network Policy.** (Commercial Health Plans - Does not apply to Medicare) If we are out-of-network with your health plan and you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.
- **TriCare Policy.** We are out-of-network with TriCare Standard and Prime Plans. If your plan agrees to provide out-of-network benefits for our services, we can provide a Superbill upon request for you to submit for reimbursement. We do not know how TriCare determines medical necessity and therefore cannot guarantee your claims for our services will be covered. Therefore, you will be responsible for paying for all services at time of service.
- **Medicare.** Patients receiving Therapy Services: A reimbursement cap of $2080 is in effect for 2020 therapy claims filed with Medicare. There are exceptions provided for certain diagnoses, however. You may request assistance from our staff if you think you may be approaching your cap or you qualify for an exception. Once you have met the therapy cap for the year, you will be responsible for paying for the uncovered services.
- **Wellness & Fitness Services.** Commercial health plans and Medicare do not cover the wellness or fitness services we offer. Therefore, we will provide you with a receipt for these services upon request.
- **Service Packages.** If you purchase a discount package of services, the package discount is applied to the last visit in the package. You must use your visits within 12 months. If you don't use your visits within that time frame or you request a refund for the unused visits, we will refund the excess amount paid, if any, after applying the package discount to the last visit and our regular cash payment fee to all other unused visits.
    - **Use of Health Savings Accounts (HSA).** If you purchase a pre-paid package plan through your HSA account we will give you a receipt for the pre-paid services that you can, at your discretion and in accordance with your HSA plan rules. If you request a refund for unused services that you paid for through your HSA, we will make the refund directly to your HSA account. If your HSA requires you to actually receive the services before submitting claims for reimbursement, we will provide you with a receipt for services actually received to date upon request. You are responsible for complying with HSA rules when determining whether the services you purchase from us can be paid from an HSA account.

- **Use of Health Reimbursement Arrangement (HRA) or Flexible Spending Account (FSA).** An HRA and FSA will only reimburse for actual services received (not pre-paid services). Therefore, if you purchase a discounted pre-paid package plan and want your HRA or FSA to reimburse you, we will provide you with a receipt that you can submit for reimbursement after you have used your entire package. Upon request, we will also provide a receipt for visits used to date that you can, at your discretion and in accordance with your HRA or FSA rules, submit for reimbursement. Please note that HRA and FSA plans have rules about what services qualify for reimbursement. You are responsible for complying with your HRA and/or FSA plan rules when determining whether the services you purchase from qualify for reimbursement.

- **Privacy Rights.** You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. If you pay for your services at the time of service, we assume you are exercising this right to privacy we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Authorization to Release Protected Health Information form before we will disclose your health information.
- **No-fault, Auto and Other Liability Policy.** If a no-fault insurance carrier is expected to pay your medical claims, for instance, the Med-Pay or Personal Injury Protection (PIP) coverage in your auto insurance plan, Medicare and your health plan expect you to exhaust those benefits before they pay any claims. Therefore, if no-fault insurance coverage is available, you hereby assign your Med-Pay/PIP or other no-fault insurance benefits to us to pay your claims until such benefits are exhausted. If the liability carrier sends payment for our claims to you or your attorney, you agree to cause such payments to be promptly forwarded to us. If the liability carrier does not pay our claims within a reasonable amount of time (generally within 120 days after we file a claim) or denies our claims, we may, at our sole discretion, accept assignment and bill your health plan. If we are not in-network with your health plan and do not accept assignment as an out-of-network provider with your health plan, payment will be due at time of service. Alternatively, and unless prohibited by state law, we may wait for payment until your case settles. If we do, you agree to pay the late payment interest fees as stated above and hereby authorize and direct your attorney, adjustor and/or insurance company involved in your case to pay directly to The Movement Clinic, LLC all sums due and owing for the services you received plus any late payment interest due from any settlement, judgment or verdict rendered in your case. This means you hereby assign and grant a lien to The Movement Clinic, LLC in any amount sufficient to pay any outstanding balance owed to The Movement Clinic, LLC and authorize/require your attorney and/or responsible insurance Payor to recognize and comply with this assignment and lien. You further understand that we are not obligated to discount any portion of our service or interest fees when your case settles regardless of the amount of your settlement, judgment or verdict or whether your settlement, judgment or verdict adequately covers your balance due to us. If we start billing your health plan at any time throughout the course of your treatment, we will withdraw the lien against your liability insurance settlement for any claims that your health plan has paid but the lien will remain on the settlement for any unpaid charges, including co-pays or co-insurance amounts.
- **Appeals Policy.** You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.
- **No-Show/Late Cancellation Policy**. All cancellations need to be made AT LEAST 24 HOURS PRIOR TO YOUR APPT in order to allow us time to fill your slot. If you do not show up for your appointment or cancel less than 24 hours, you will be charged 100% the cost of your session.

I HAVE READ, UNDERSTAND AND AGREE TO THESE PAYMENT TERMS.

X _____ Date: _____

Signature of Patient and/or Guardian

X_____ Date: _____

Signature of Provider Representative

A photocopy of this agreement is to be considered valid, the same as if it was the original.