

FINANCIAL RESPONSIBILITY UNDERSTANDINGS

Thank you for choosing Zenith Rehabilitation, LLC for your therapy needs. We are committed to providing quality health care. To ensure this, we require that each client/patient read and agree to the following financial understandings prior to beginning treatment. If the client/patient is a minor, a co-signature of a parent or guardian is require at each opportunity.

DEDUCTIBLES/CO-PAYMENTS/PAYMENTS

Our insurance contracts require us to collect deductibles, co-insurance and co-pays. Co-pay amounts will be collected at each visit prior to services rendered. For your convenience we accept Visa, MasterCard, Discover, and/or cash. We *do not* accept personal checks. ______Initial

All patients and guarantors or financially responsible for timely payment of our services. _____Initial

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Insurance Coverage: Your insurance policy is a contract between you and your insurance plan. We cannot efficiently bill you insurance company unless you provide us with current and valid insurance information. We will file claims to your insurance company, however, health plans are not all the same and they do not always cover the same services. In the event that your health plan determines that a service is "not covered" you will be responsible for the entire charge. This office is not responsible for disputing decisions made by your insurance carrier regarding coverage. _____Initial

We expect you to familiarize yourself with the benefits and limitation of your insurance policy including your deductibles, coinsurance and co-payment amounts. If items billed to your insurance receive no reponse within 45 days, you will be billed and the account considered past due. It is your responsibility to notify our office when either your insurance plan or benefits change. _____Initial

Self Pay: If you have *no* insurance, you understand that payment will be made at the time the services are rendered unless financial arrangements have been made PRIOR to the services. If your are unable to make payment in full, you understand that you should call the billing department immediately @ (816) 478-7800 to make payment arrangements. With arrangements, a statement will be emailed to you each month showing the total balance due. You understand that if you break the terms of agreement and/or no payment has been received after 45 days, your account may be referred for collections. If your account is referred for collections, you understand that you will be responsible for the balance, as well as, all collection costs and reasonable attorney's fees. _____Initial

Cancellation/No Show Policy: If you do not give 24 hours notice of cancellation of a scheduled appointment, a full charge for the office visit will be billed to the financially responsible party. Medical or family emergencies are exempt with notice given to the clinic as soon as possible regarding the event. _____Initial

I have read, understand, and agree to the written financial policies for Zenith Rehabilitation LLC:

Signature of Client/Patient

Date

Printed Name of Client/Patient