Authorization for Claims, Payment, or Reviews

1. **For Medicare Recipients:**
   I certify that the information provided to me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to Empower Hand Therapy and Rehabilitation, LLC for any services furnished to me during the applicable periods of medical care.

2. **Assignment and Coordination of Insurance Benefits:**
   I agree to provide information regarding all health insurance benefits to which I/the patient may be entitled. I hereby assign payment(s), if any, from insurance carrier(s) health benefit plan to Empower Hand Therapy and Rehabilitation, LLC for services rendered to the patient. I hereby authorize payments directly to Empower Hand Therapy and Rehabilitation, LLC, including any benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to Empower Hand Therapy and Rehabilitation, LLC for services rendered to me during the applicable periods of medical care.

3. **Unauthorized, Non-covered, or Out of Plan Services:**
   I understand and acknowledge:
   - If my insurance carrier or administrator of benefits does not consider any services rendered covered services, or has not authorized these services, they will not pay, and I agree to pay for these services.
   - **One or more of my providers may not accept insurance or may be out of network with my health insurance.**
   - In the case of out of plan/network provider or services, there may be reduced benefits and I may be required to pay a higher copay, deductible or coinsurance amount.

4. **Self-Pay Policy:**
   Our fee is $180 for the Evaluation (first visit) and $150 for each follow-up visit.
   Please come prepared to make a payment at each visit. We accept cash, check and major credit cards. **We require a credit card to be maintained on file** for charging visit fees, medical supplies, now show and late cancel fees. You may still pay for patient responsible charges with cash, check, or HSA/FSA cards by presenting these at the front desk prior to your treatment. At the end of each treatment session, you will receive a bill that you can submit to your insurance company.

5. **Responsibility for Payment:**
   - I hereby agree to pay any and all charges that are not covered by my insurance plan, such as deductible, coinsurance, copay, medical supplies, no show, and late cancel fees. **We require a credit card be maintained on file** for charging any fees determined to be patient responsibility. You may still pay for patient responsible charges with cash or check prior to your treatment to avoid the charges being run on the credit card on file.
   - I hereby understand that I am solely responsible for the balance due on my account. If your account balance matures over 120 days and remains unpaid, your account will be sent to collections and we will no longer be able to assist you with the account. Any accounts in default and sent to collections could be assessed attorney fees, court costs and interest of 1% per month.

- In the event that your check is returned by the bank, there will be a $20 returned check fee assessed to your account. This amount will be collected directly from your credit card on file.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered, and accept the above conditions and terms; and I agree to pay all charges for which I may be legally and/or contractually responsible, including but not limited to health insurance deductibles, copayments, and non-covered services. *I understand and agree this document will remain in effect for my present outpatient visit and any future outpatient office visits to Empower Hand Therapy and Rehabilitation, LLC, unless specifically cancelled in writing by me.* I understand that I will be asked to review and sign this form once per calendar year as long as I remain a patient of Empower Hand Therapy and Rehabilitation, LLC.

_____	_____	_____	
Patient/Guardian/etc. (signature)	**Patient/Guardian/etc.** (print name)	Date	Time

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Relationship to Patient (if not signed by patient)