



Health Insurance Billing Policy

It is the policy of The KOR PT (Dimond Physical Therapy, LLC) to bill your primary (and secondary if applicable) insurance policies as an accommodation to you. Our services are typically covered by most health insurance policies. However, there are variances in benefits among insurance companies and among policies, and not all services will always be covered by every insurance company. Furthermore even if a service is covered, the insurance company may not pay the full amount of the charge. You agree to pay the full amount of any service provided to you regardless of insurance benefits.

Co-payments will be due at the time of each visit. Co-insurance charges will be billed to you after payment or explanation of payment by your insurance company. Should prior authorization/referral be required by your insurance provider, it is ultimately your responsibility to ensure that the process has been initiated and completed. Any fees not covered by your insurance are your responsibility. Amounts not paid when due shall bear interest at one percent (1%) per month. You shall be responsible for any and all costs of collections including reasonable interest, collection costs and attorney's fees.

By signing below I hereby authorize my insurance company to pay The KOR PT directly, the amounts due for services rendered to me or to my dependents. I further authorize the release of my Physical Therapy records, as needed to process my insurance claims, as well as with other health care providers if needed to allow better collaboration between providers. I understand that I am responsible for all unpaid charges owed to The KOR PT for services rendered and/or product purchased.

Signature: _____ Date _____

Cancelation Policy: We require at least 24 hours' notice (by the business day before) if an appointment needs to be canceled or rescheduled. A \$25 cancellation fee will be applied (at The KOR's sole discretion) for any missed, canceled or rescheduled appointments not within this time frame. (Initials: _____)

To be completed by Staff

The benefits quoted below are not a guarantee of benefits, nor is it a guarantee of payment. Our clinic provides a summary of the benefits when we can, as a courtesy to the patient. We strongly suggest and encourage you to call your insurance company to verify your specific benefits.

Patient Name: _____

Co-pay: _____ Deductible: _____

Coinsurance: _____ Visit Limit: _____

Prescription or Authorization req'd: Yes / No

Out of Network Benefits: Yes / No

If so, please talk with us about specific financial agreements.

Ins Co. Rep: _____ Date Called: _____

I certify that I have read the above quoted benefits and that I understand they are not a guarantee of benefits, merely provided to me as a courtesy by The KOR PT. I understand that it is my responsibility to call my insurance company and verify my insurance benefits and to pay for all services. The KOR PT is in no way responsible for the verification of medical insurance benefits.

Signature: _____ Date _____

Release of Information and Consent for Treatment

I hereby consent to Physical Therapy services, evaluation and treatment by The KOR PT as directed by my Physician and/or Physical Therapist. I have either reviewed or received a copy of the HIPAA Notice of Privacy Practice for Personal Health Information from The KOR PT. I authorize The KOR PT to release and discuss my Physical Therapy records with my physician.

Physician's Name: _____

Patient Signature: _____ Date: _____

Guardian (if under 18): _____ Witness: _____