SUMMIT
REHABILITATION ASSOCIATES

CANCELLATIONS & NO SHOWS: Cancellations or changes to an appointment must be requested 24 hours prior to scheduled appointment time. Repeated late cancellations or no-shows are disruptive to the optimal delivery of care to you & our other patients. Missed appointments also affect the consistency of your own rehabilitation program. If you no show your appointment at any time during your treatment, Summit has the right to discontinue care. Two late cancellations may also result in discontinuing physical &/or occupational therapy services at Summit Rehabilitation Associates. If you are discharged from our care, your referring provider &/or case manager will be notified of the reason for discharge from therapy.

TIMELINESS: We value your time & strive to keep your wait time to a minimum. Occasionally, we are delayed by an unexpected event with another patient, but please be assured that the quality of your treatment will not suffer. If you arrive late, your treatment will end at its scheduled time so we may keep the next treatment times on schedule.

COPAYMENTS ARE DUE AT THE TIME OF EACH TREATMENT: Copayments are due on the day services are rendered. It is the responsibility of you, the patient, to pay the copayment at the time of check in. The front desk is not responsible for asking for this copayment each time.

MEDICAL SUPPLIES: Some of the medical supplies we provide to assist with your treatment are not covered by your health plan. You will be asked to pay for these items at the time services are rendered. We accept cash, checks & Visa/MC.

FINANCIAL POLICY: If our providers are preferred with your health plan, we are contractually obligated to bill your health plan. Secondary health plans are billed as a courtesy to you, but it is important that we be provided with the proper information.

Your insurance policy is a contract between you, your employer, & the insurance company. We are not a party to that contract, or the benefits provided by that contract. We do check benefits & advise if there is anything "out of the ordinary"; however, it is your responsibility to check your own OUTPATIENT PHYSICAL THERAPY BENEFITS, talk to your Primary Care provider for authorizations if necessary & follow up with the insurance company if you have any questions regarding the way they have or have not processed your claims.

It is important to communicate any financial problems as soon as possible. Please contact the Accounts Receivables Department to discuss a mutually agreeable payment plan so you will not jeopardize your credit. If you do not have insurance, a discount can be offered, but you must talk to the Accounts Receivables Department to discuss your payment options.

We keep a record of the health care services we provide you. For a fee, you may ask for a copy of that record. Please refer to the NOTICE OF PRIVACY PRACTICES for further information regarding your rights in relation to your private medical records.

- I understand that Summit Rehabilitation Associates is not responsible for any personal belongings I bring to this clinic.
- I understand that I am ultimately responsible for all charges for services rendered regardless of litigation, insurance reimbursement or pending workers' compensation claims. I understand that the parent/guardian responsible for any minor child or person is responsible for payment of services.
- I authorize Summit Rehabilitation Associates to release to my insurance company, any information necessary to adjudicate payment of my medical claims.
- I authorize payment to be sent directly to Summit Rehabilitation Associates for any benefits available as outlined by my insurance policy.
- I understand that this authorization, unless expressly limited to me in writing, will extend to all aspects of treatment, including testing &/or treatment for sexually transmitted diseases AIDS or HIV infection, alcohol &/or drug abuse, or mental health conditions.

I ACKNOWLEDGE THAT I READ & UNDERST& THE POLICIES AS OUTLINED ABOVE. SIGNATURE IS VALID FOR 90 DAYS OR FOR THE DURATION OF TREATMENT.

Patient Signature: _____	Date: _____
If Minor, Responsible Party: _____	Date: _____

SUMMIT REHABILITATION ASSOCIATES NOTICE OF PRIVACY PRACTICES

I have reviewed &/or been given the option to receive a copy of the Summit Rehabilitation Associates PLLC Notice of Privacy Practices. I know the terms of this Notice & have been advised I can review if again at any time as I request.

Patient Signature: _____	Date: _____

Please tell us how you learned of our service:

☐ I was a former patient ☐ Internet ☐ Website: _____

☐ Family/Friend/Co-worker ☐ Doctor Recommendation ☐ Other: _____