Over the Mountain Rehab, Inc.
Financial / Privacy Policy

ALL PAYMENTS ARE EXPECTED AT TIME OF SERVICE.

Primary and secondary insurance companies are billed as a courtesy to the patient. **Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance, co-payments, and deductibles**. Supplies and other over-the-counter items are not covered by insurance and must be paid for at the time of service. Payments not received from the insurance company within 60 days of the date of service will become the responsibility of the patient. Patients with an outstanding balance of sixty (60) days overdue must make payment arrangements prior to scheduling new appointments. Over the Mountain Rehabilitation accepts cash, personal checks, VISA and MasterCard. There is a service charge for all returned checks. Account information for unpaid balances exceeding ninety (90) days will be forwarded to an outside collection company and the patient will be responsible for all costs related to this action.

MAXIMUM VISITS

Most insurance policies have a maximum allowable number of visits for physical and occupational therapy. This may include visits to other therapy facilities throughout the year. It is the responsibility of the patient to notify Over the Mountain Rehabilitation of all therapy visits. If insurance denies coverage because the maximum number of visits has been exceeded then the patient will be responsible for all charges related to uncovered visits.

MISSED APPOINTMENTS / LATE CANCELLATIONS

Broken appointments represent a cost to us and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-cancelled appointments. There will be a charge of $35.00 for missed or late cancelled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

CONSENT FOR RECURRING OUT-PATIENT TREATMENT

I consent to necessary treatment, including drugs, therapy, testing, or other studies that maybe be used by the attending therapy or his / her staff.

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I authorize the release of any and all of my treatment and service information to third parties to facilitate billing, collection, or referrals for services to other providers.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Over the Mountain Rehabilitation reserves the right to modify the privacy practices outlined in the notice. I acknowledge receipt of a copy of the Notice of Privacy Practices from Over the Mountain Rehabilitation.

I have read and understand the Over the Mountain Rehabilitation Financial / Privacy Policy. I agree to assign insurance benefits to Over the Mountain Rehabilitation whenever necessary and acknowledge that I have read and understand the Notice of Privacy Practices.

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Name of Patient (print)

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Signature of Patient or Representative Date