PHYSICAL DIMENSIONS
CHIROPRACTIC, PHYSICAL THERAPY, SPORTS MEDICINE
www.physicaldimensionsihg.com

INVERNESS : 303.925.1050
FAX: 888.808.8236
INFO@PHYSICALDIMENSIONSIHG.COM
88 INVERNESS CIR E., A-106 ENGLEWOOD,CO 80112

Financial Policies

Health Insurance:

Assignment of Benefits:

I hereby assign payment directly to PDIHG/PhysioMed, who represents this clinic to payor groups for medical benefits payable to PDIHG/PhysioMed. I will update billing information as soon as any changes occur in my insurance coverage including my address and personal contact information.

The insurance (managed care) industry manages your care and dictates what they will pay for based on what they feel is medically necessary. I understand my health insurance is a contract between myself and insurance carrier. As a service to our patients, we will bill insurance companies for services rendered, will resubmit a denial only one time and allow a total of 60 days for complete payment. No guarantees of coverage are implied by PDIHG/PhysioMed. Unique plan requirements like pre-authorization, whereby such requirement is not clear in the initial verification of benefits process, are the responsibility of the patient to be compliant with as those requirements are not always clearly apparent at verification of benefits. Any denials over pre-authorization requirements default to our policy of billing patient's insurance one time correctly based upon our review of your benefits portal.

I am financially responsible for any applicable deductibles or co-pays. I also understand that I am financially responsible for any charges not covered by this assignment; including any denials for any reason. Any unpaid balances after 60 days will become patient responsibility and I understand these charges will be charged to my credit card on file 10 business days after notification via phone and/or email. I understand that I will be held responsible for any costs incurred regarding collection of payment for services rendered, including 40% charge if we must send to our collection company, as well as any statement fees, late charges and 18% annual interest.

Initial _____

Auto Cases:

We do require a credit card on file. If there is no med-pay, we will keep the credit card on file until the account has been settled. We do reserve the right to charge the credit card if the case has been settled and we have not received payment or correspondence within 60 days. We do offer a 20% discount for payment in full within 60 days of the date of dismissal from active care. Without Med-Pay benefits or after Med-Pay benefits are exhausted we will charge a $125/month charge to apply towards the balance. **We DO NOT bill health insurance** for auto cases due to the higher documentation standards necessary to document impairment, causation, etc. and expanded treatment times due to the widespread injuries related to an auto accident.

Initial _____

Missed Appointment:

Unless **cancelled at least 24 hours in advance**, we reserve the right to charge a **$75.00** missed initial evaluation fee, **$50.00** missed extended appointment fee or a **$30.00** missed regular appointment fee. We have voicemail available 24 hours a day, 7 days a week and email should you need to cancel during non-office hours. We are aware that unforeseen events result in a missed appointment and can be discussed on an individual basis.
Habitual no-shows or late cancellations will result in higher cancellation fees, and/or dismissal from the clinic.
A patient who is eligible for 3 missed appointment fees within a 3 month period **will be charged the full visit amount** ($65-$100 depending on the visit type) for all subsequent no-shows or late cancellations. It is to the discretion of the doctors to dismiss the patient from the clinic.

Initial _____

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Email/Phone Consultation Fee:
I understand that I may incur a nominal office fee for phone or **email consultations** requiring physical dictation in lieu of a normal office visit. I also consent to email communications of my medical records, MRI images, etc with other providers and myself as a convenience. No method of communication is completely secure so we do not email communications containing social security numbers, credit card numbers etc. Initials placed below consents to the convenience of email communications with the intent of more efficient doctor patient communication.
Initial _____

Release of Records:
I do ____/ do not _____ authorize other healthcare providers to **release or obtain any medical records**, images, or reports to/from PDIHG/PhysioMed for the purpose of providing or obtaining medical information pertaining to my treatment. I will specify any restrictions to any party I authorize to receive said information from PDIHG. Note any limitations to that information ie time period, type of records, etc.

Minors:
Minors are welcome to come without their parents for their visits. However, if a parent is not going to accompany the child we do require a credit card on file that will be charged after each visit for any applicable co-pays, co-insurance, or deductibles.
Initial _____

I acknowledge that I have been provided with a copy of the Notice of Privacy Practices and have, therefore, been advised of how health information about me may be used and disclosed by Physical Dimensions IHG and how I may obtain access to and control of this information.
Initial _____

PHYSICAL THERAPY SERVICES; MEDICAL DIRECTOR AND ADVANCED BENEFICIARY (ABN) NOTICES:
I hereby understand and consent that ALL physical therapy services at PDIHG/PhysioMed are billed under my medical benefit with supervision by **medical director** Taylor Semian FNP-C. This allows for continued high level of standard of care with longer appointment duration and lower copays among other benefits. Your insurance explanation will reflect this medical director model of care. Mrs. Semian FNP-C reviews all exams and treatment plans, is onsite and in addition to being on call with PT staff for consultation on your case throughout care.
Initial _____

I understand other therapies in the office, including manipulations, will be managed by the physical therapist Dr. Dustin Szenderski DPT and will reflect this on the EOB. I also understand these therapies will be applied to my physical therapy benefits for BCBS/Anthem and United. **Do to capitation of some insurances, including United and BCBS/Anthem, I understand I may incur a supply or visit surcharge due to the elongated appointment times and supplies not covered by my plan. This allows for a higher standard of care our clinic deems necessary.**
Initial_____

Name (print):_____

Signature:_____ Date:_____