Date _____ Provider _____ Patient _____

Lancaster Orthopedic Group
Physical and Occupational Therapy
Financial Policy

- I understand that payment for services is due at the time services are rendered. Any outstanding balances are due within 30 days, unless prior arrangements have been made with the Business Office. All balances that reach 90 days or older may be sent to a collection agency. **All accounts sent to a collection agency will be charged an additional 18% collection fee.**
- We will gladly try to answer any questions related to your insurance, but insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. You must realize that your insurance is a contract between you, your employer (possibly), and the insurance company. We are not a party to that contract except where we are contracted as preferred providers.
- If we do participate with your insurance company, all services performed in our office and at the hospital will be submitted to your insurance. All co-pays and deductibles are your responsibility and are due at the time services are rendered.
- If we do not participate with your insurance company, we will bill your insurance carrier as a courtesy to you. We do not accept payment from them as payment in full for services performed. Any balances not covered by the insurance company become your responsibility.
- We must emphasize that as an orthopedic practice, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from the date services are rendered. Therefore, it is often necessary for you to inquire and explore your benefits with your insurance carrier. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our business office for assistance in the management of your account.
- I have read and fully understand the financial policy set forth by Lancaster Orthopedic Group and I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby assign all medical benefits to which I am entitled, including Medicare, Private Insurance and any other health plan to Lancaster Orthopedic Group. This assignment is to be considered as valid as the original.

_____ _____
Date **Signature of Patient or Authorized Representative**

Consent for Treatment

- I understand that a prescribed course of treatment will be adequately explained to me (and my parent if I am a minor) by the therapist and do hereby voluntarily consent or permit any associated therapist of Lancaster Orthopedic Group Inc. of Lancaster, PA to proceed with treatment based on the therapist's evaluation and the attending physician's orders. I agree to notify the appropriate staff member of any adverse effects from any aspect of my treatment immediately. I understand that Lancaster Orthopedic Group will not be held liable for any injury sustained while using fitness equipment during a course of rehabilitative treatment.
- In the case of a minor patient (under the age of 18) I hereby authorize Lancaster Orthopedic Group to administer Physical or Occupational Therapy care deemed necessary for this course of treatment when I am unable to accompany my son/daughter for treatment.

_____ _____
Date **Signature of Patient or Authorized Representative**

Consent for Therapy Student Observation

- From time to time we have medical students and physician assistant students shadowing a physician as part of their program requirements. You are consenting to this process.

_____ _____
Date **Signature of Patient or Authorized Representative**

Consent for Release of Information

- I authorize release of any medical information concerning my treatment to my insurance company, family physician, referring physician, primary care physician, any physician in the course of care for this issue, any treating facility, my employer or rehab nurse in the case of workers' compensation, or the following persons:

  [ ] Spouse [ ] Children [ ] Parents, if over 18 [ ] Sports Trainer/Coach [ ] Other family member(s)

  Name(s): _____

- Please specify an Emergency Contact:

  Name: _____ Phone: _____

The life of this Consent for Release of Information form is one year (12 months) from the date you sign unless a new consent is signed.

_____ _____
Date **Signature of Patient or Authorized Representative**

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