HEIDEN ORTHOPEDICS

Physical Therapy Financial Policy & Privacy Practices

In accordance with the Federal Truth in Lending Act, all physicians are required to give their patients information in connection with the extension of credit:

- **Basic Policy**: Patients are responsible for all medical bills resulting from services provided them by Heiden Orthopedics. It is the patient's responsibility to know their insurance contract benefits, assure collection of insurance payments and to resolve disputed claims with their insurance company.

- **Cancellation/No Show Policy: 24 hours** notice of cancellation is required for any appointment. Any cancellations or no shows within 24 hours, will be assessed a **$50.00 fee** on the date of the appointment. Please notify our office as soon as possible of any cancellations.

- **Uninsured Patients:** Uninsured patients must make full payment for all services at the time they are provided. If the patient has chosen our Self Pay Policy, they will be responsible for $125.00 at the time of session.

- **Insured Patients:** Please provide your identification card from your Primary and any Secondary Insurance to the receptionist at the time of your first visit. It is the patient's responsibility to contact their insurance company to determine benefits, or to answer questions regarding payments or denied claims. As a courtesy, Heiden Orthopedics will file primary insurance claims. If a dispute should arise between Heiden Orthopedics and the insurance company, it is the patient's responsibility to resolve the dispute, as the insurance policy is a contract between the patient and the insurer.

- **Acknowledgement of Privacy Practices:** I understand the email and/or phone number provided by me to Heiden Orthopedics may receive appointment reminders, updates about products and services, promotions, special offers, news & events. We will treat your data with respect and do not share your information with third party advertisers.

  The purpose of this Authorization and Release form is for your protection. The H.I.P.A.A. (Health Insurance Portability Accountability Act) of 1996 was created with the sole purpose and goal of protecting patient's medical records and financial information. We will not share this information without your consent. We urge you to complete this form to allow us to better serve and protect your private information. We appreciate your attention to this sensitive matter. Please be specific when designating your choices.

  I (patient/parent/guardian) authorize the staff of Heiden Orthopedics to release any:
  ☐ FINANCIAL INFORMATION ☐ MEDICAL INFORMATION to the following people:

  1. _____ 2. _____

  Heiden Orthopedics will not release my medical information to individuals without a signed release form.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of my patient records. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Private Insurance and all other health plans to Heiden Orthopedics. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be as valid as the original. By signing below, I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. I agree that interest may accrue on all past-due amounts at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principle amount(s) owing as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today. I hereby agree to the terms stated herein and authorize said assignee to release all information necessary to secure payment.

I have read and agree to the Financial Policy and Privacy Policy of this Office.

Print Name of Patient: _____ **Date:** _____

Signature of Patient/Guardian: _____ **Date:** _____