696 Hampshire Road, Suite 180A
Westlake Village, CA 91361
Phone: 805.497.1700 Fax: 805.497.1066

INSURANCE INFORMATION

Health and accident policies are an arrangement between you and your insurance company. You are personally responsible for all services rendered in our office. As a courtesy, our office will bill your primary insurance. All unpaid charges will be billed directly to you, the patient. We accept assignment of benefits. Your insurance company will send payment directly to our office. Should your insurance company send you payment for our services; you will be responsible to reimburse Meridian Hand Therapy, Inc. We will promptly credit all received payments from your insurance company. *Please also be aware that some insurance policies have a maximum number of visits they will allow per calendar year and that these may be combined with physical therapy, chiropractic care, speech therapy, and/ or acupuncture. If these visits have been used, you will be financially responsible.*
Patient name (print): ______________________________ Insurance Company: ___________________
Our office will not enter into a dispute between you and your insurance company over claims. This is your responsibility and obligation. _________ **(Patient initials)**

PRIVATE & MEDICARE INSURANCE – The fees charged in our office are comparable to those charged by other occupational therapists in this area with similar qualifications.

MEDICARE **–** In order for your Medicare benefits to apply, you must see your doctor every 30 days and obtain a new prescription for occupational therapy. You are responsible for obtaining this prescription from your doctor. Please note: if your doctor is not a Medicare provider, you may be financially responsible for the cost of any supplies issued. You are also responsible to notify our office if you are receiving home health services. Medicare will not pay for services rendered by our office if you are receiving home health services at the same time. If you do receive our services and are also receiving home health services you will be financially responsible.
ARE YOU CURRENTLY RECEIVING HOME HEALTH? PLEASE CHECK: YES___ NO____
IS MEDICARE AWARE THAT YOU HAVE A SECONDARY INSURANCE? PLEASE CHECK: YES___ NO____

WORKER'S COMPENSATION – If you are hurt on the job, your employer's workers compensation will pay 100% of your care upon authorization from the adjuster. Please be advised that if your case is not accepted and authorized, you will be responsible for the entire balance. Payment will be due in full immediately.

PERSONAL INJURY/AUTO ACCIDENT – If you have Med-pay coverage on your automobile policy, we will bill them for prompt and direct payment. Med-pay will cover your doctor bills regardless of who was at fault. If there is no Med-pay coverage, we will bill your health insurance. Liens will only be taken on a case by case situation.

My signature below states that I have read, and have been informed of my insurance benefits, as quoted by my insurance company. I am aware of my financial responsibility to Meridian Hand Therapy. I understand and agree to the above terms and conditions.

Patient signature: ____ Date: ________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES Office Manager, Privacy Officer, 805-497-1700

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signature: ____________________________ Date: _________________________
Print Name: **___________________________ Telephone: _________________________**

If not signed by the patient, *please indicate relationship*: **___ Parent or guardian of minor patient ___ Guardian or conservator of an incompetent patient ___ Beneficiary or personal representative of deceased patient**

Name of Patient: _______________________________

MERIDIAN HAND THERAPY CANCELLATION POLICY & ADDITIONAL CHARGES
In order to ensure appointment times for each of our patients, we will enforce a **$40.00 cancellation fee** for appointments that are not cancelled at least 24 hours **before the scheduled time**. This fee will be applied to each missed appointment and must be paid by the patient**. (Your insurance company will not cover this charge).**
Cash Patients: $125.00 for the initial evaluation and $85.00 per session thereafter plus the cost of supplies is the discounted cash rate for patients without insurance.
Returned check charge: $15.00 per check
Late payment charge: $10.00 or 1.5% (whichever greater) will be added to your account along with a collection service and/or attorney fees for delinquent accounts. There will be a $15.00 office charge for the copying of medical records.

I am aware of my financial responsibility to Meridian Hand Therapy. I understand and agree to the above terms and conditions.

Patient signature: ______________________________________ Date: _______________________