Robart Rehabilitation & Wellness Center

Finance Agreement

Robart Rehabilitation & Wellness Center is committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) AND TAKE YOUR PICTURE FOR YOUR FILE.

*APPOINTMENTS-24 hour notice must be provided in the event you cannot keep an appointment. Should you not provide this notice a cancellation fee of $25.00 may then be added to your account.

*CO-PAYMENTS-By law we MUST your carrier designated co-pay. This payment is expected at the time of each service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service, and we subsequently send you a statement, an administrative fee of $5.00 may be added to your account.

*FMLA/and or Workman Comp-There is a $25.00 charge for completion of Workman Comp or FMLA forms.

*Private Insurance Authorization for Assignment of Benefits/Information Release; I, the undersigned, authorize payments of medical benefits to Robart Rehabilitation and Wellness Center for services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to be released to my insurance company concerning health care, advice, or treatment provided to me. This information will be used for the purpose of evaluation and administering claims.

*SELF-PAY-PATIENTS- Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

*MEDICARE-We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare Benefits to be made on my behalf to Robart rehabilitation and Wellness Center, for any services furnished to me. I authorize any holder of medical information about me to release to CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluation and administering claims of benefits.

*DIVORCED/SEPERATED PARENTSOF MINOR PATIENTS-The parent who consents to the treatment of minor child is responsible for payment of services rendered, Robart Rehabilitation & Wellness Center will not be involved with separation or divorce disputes.

*INSUFFICIENT FUNDS CHECKS- A $30 fee will be charged to patients account for checks returned due to non sufficient funds.

If account becomes delinquent and sent to collection agency, patient is responsible for all fees associated with collection of delinquent balance including and not limited to: Collection fees, attorney fees and court costs.

Patient Name_____ Date_____

Responsible Party Signature_____ Date_____