Dr. Steven S. Goldberg, MD - Physical Therapy

Orthopedics and Sports Medicine Rehabilitation

Financial Policies

We have found that communication with our patients regarding our policies assists us in providing the best service to you. Please take that time to carefully read the sections which pertain to you.

PRESCRIPTIONS

Most insurance companies require a valid prescription from a Florida Licensed Physician, Dentist, Podiatrist or Nurse Practitioner for physical therapy reimbursement. It is the patient's responsibility to ensure the prescription is up-to-date and valid.

Please initial: _____

MEDICARE

Adhering to Medicare guidelines for physical, speech and occupational therapy, there are financial limitations for therapy services. **The dollar amount for the 2022 limitation from January 1, 2022 through December 31, 2022 is $2,150. There is a deductible of $233 for 2022** that must be met as well. You will be responsible for any therapy services provided beyond the Medicare limitation.

Please initial: _____

INSURANCE

We are happy to bill your insurance company as a courtesy and convenience if we are provided with appropriate billing information. If we do not receive proper information, payment may be required at the time services are rendered. As a courtesy we will verify your insurance benefits for physical therapy. ***However, we strongly advise you to contact your insurance company directly to obtain this information since it is ultimately the patient's responsibility to know and understand their insurance benefits***.

Please initial: _____

COPAYS, COINSURANCE, DEDUCTIBLES

It is our policy to collect co-pays at the time of service.

Co-insurance is an estimated amount and we may not know the exact amount until the claims are processed. Therefore the estimate is based on the *average* patient responsibility. If there is a balance due after your insurance processes we will bill you for the difference between the amount you have paid and what the insurance states is the patient responsibility amount. If you have a deductible which has not been met you may be asked for payment on this as well.

Please initial: _____

NO INSURANCE

We are happy to provide services to patients not participating in a health insurance program, but we must insist payment be made at the time services are rendered.

Please initial: _____

[SEE BACK TO FINISH]

AGREEMENT/AUTHORIZATION

"I hereby assign, transfer and convey payment and authorize said payment to be made directly to Dr. Steven. S Goldberg's Office for any medical benefits, sick benefits, injury benefits due because of liability of a third party, or proceeds of all claims resulting from liability of a third party, payable by any party, organization, etcetera, to or for discharge or completion of all outstanding obligations related to this medical treatment. I further agree that this assignment will not be *withdrawn or voided* at any time until this account is paid in full. I understand that I am responsible for any charges not covered by my insurance company and for deductible and copays. I realize that the provider may be required to release medical information on my behalf for the purpose of obtaining payment, to settle a dispute to facilitate payment and other reasons outlined in our Privacy Policy. Dr. Steven. S Goldberg's Office has the right to charge reasonable collection fees and add these fees to my account balance if I fail to pay outstanding charges on my account. The undersigned individually obligates him/her to pay the account of the provider in accordance with the regular rates and terms of the provider:

_____ _____

Name (print) Date

_____

Signature

HIPAA Contact Information

May we leave a message regarding your **Appointments?** *(Please circle answer)*			May we leave a message discussing **medical Information?** *(Please circle answer)*		
Home Phone (include Auto Call)	Yes	No	Home Phone	Yes	No
Mobile Phone (include Auto Call)	Yes	No	Mobile Phone	Yes	No
Mobile Text (include Auto Call)	Yes	No	Mobile Text	Yes	No
Work Phone	Yes	No	Work Phone	Yes	No
With Another Person	Yes	No	With Another Person	Yes	No
Send via Mail	Yes	No	Send via Mail	Yes	No
Send via Email	Yes	No	Send via Email	Yes	No

EMAIL ADDRESS: _____

Please List person(s) authorized to discuss your medical information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Emergency Contact: _____ Phone #:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF "Patient Bill of Rights," "Notice of Privacy Practices," and "Medical Records Policy."

I have been offered, and/or have received the "Patient Bill of Rights," "Notice of Privacy Practices," and "Medical Records Policy" as it pertains to Physical Therapy from Dr. Steven S. Goldberg's Office.

Signature_____ Date_____