Payment and Financial Responsibility Agreement

Thank you for choosing Penn Ohio Rehabilitation where we are committed to providing you with a superior therapy experience. Your health is important to us and we want to make sure that you receive the care you need at the time you need it. We realize that temporary financial problems may affect your timeliness of payment, if such problems do arise please contact us promptly for assistance in the management of your account. Penn Ohio Rehabilitation is obligated by law to collect all co-pays, deductibles and coinsurances that your insurance company may apply. As a courtesy, we will verify your health insurance coverage and notify you of the benefits that we are provided, however we are not always privileged to all information or given accurate information from your insurance company.

We strongly recommend that you also contact your insurance company to discuss your insurance benefits and financial responsibility.

Insurance: We participate in most insurance plans, including Medicare. It is your responsibility to keep us updated on any insurance changes that occur throughout your course of care.

Claim Submission: We will submit claims on your behalf to your insurance and assist you in any reasonable way to help get your claims paid.

Copayment: All copays must be paid in full on the date of service unless a written payment plan has been established with the office.

Deductibles: You will be responsible for all charges that your insurance company applies to your deductible. Portions of the deductible are expected to be paid at the time of service as follows with the remainder of the balance to be paid in full upon receipt of statement.

Deductible Range	Payment Per Visit
$100-1000.00	$30.00
$1000-5000.00	$50.00
$5000 +	$70.00

Co-Insurance: A coinsurance may be applied to your coverage until an out of pocket maximum is met. Coinsurance amounts vary based upon the percentage and amount billed. Portions of the coinsurance are expected to be paid at the time of service at a rate of $1.00/percentage with the remainder of the balance to be paid in full upon receipt of statement. (example: 20% coinsurance = $20.00/visit payment)

Cash Payment: If you are not insured by a plan we participate in a cash fee will be applied to each date of service at a rate of $75.00 for the initial visit and $50.00 for each visit after. Payments are due at the time of service.

Overpayment: All overpayments on accounts will be returned to you within 45 days of the account being deemed paid in full.

Nonpayment: Statements will be mailed out monthly and payment is expected upon receipt. If your account is 90 days past due you will receive a phone calling requesting payment on your account within 30 days, should no attempt to reach us to make a payment or set up a payment plan your account will be referred to a collections agency.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of Patient or Representative: ________________________________ **Date:**______________