ALLSTON BROOKLINE SOMERVILLE EAST CAMBRIDGE SWAMPSCOTT WEST ROXBURY WATERTOWN

800-346-9153

www.bostonsportsmed.com

POLICIES REGARDING SCHEDULING, TREATMENT, & REIMBURSEMENT

Boston Sports Medicine, Inc. requires a copy of any insurance identification card and other insurance used for payment and a valid photo ID.

HMO PATIENTS:

- All HMO/Managed Care patients are responsible for obtaining referrals from their Primary Care Physician prior to their first appointment.
- All HMO/Managed Care patients are responsible for making sure that they do not exceed the number of visits allowed or on the referral. Boston Sports Medicine, Inc. recommends that all patients call their PCP to authorize additional visits at least 5 business days before the last appointment covered by the referral.
- Any treatment received without a valid referral or beyond your insurance company's authorization or benefits will be your financial responsibility. Boston Sports Medicine, Inc.'s standard fees for services rendered will apply.

MEDICARE PATIENTS:

- **Medicare requires that you see your referring physician every 30 days after the visit when your physician first prescribed physical therapy. A new written prescription for physical therapy must be obtained every 30 days to authorize Medicare to pay for the continued treatment.**
- **Any treatment received without a valid written prescription will be your financial responsibility. Boston Sports Medicine, Inc.'s standard fees for services rendered will apply.**

ASSIGNMENT OF INSURANCE BENEFITS & RELEASE OF MEDICAL INFORMATION

- I hereby authorize and request my insurance company to pay directly to Boston Sports Medicine the amount due me for Medical Benefits under this claim.
- I hereby agree to pay Boston Sports Medicine all charges not covered by my insurance company. I also agree that if any insurance payments are paid directly to me, I will pay Boston Sports Medicine within 15 days of receiving the insurance payment.
- I hereby authorize the release of any medical information necessary to process my insurance claim(s) and request that the payment for all benefits be made to Boston Sports Medicine for services described. I also authorize the release of any medical records to other physicians/insurance companies for services needed to render necessary medical care pertaining to my services with Boston Sports Medicine.

______ **(Please Initial) I AM ULTIMATELY RESPONSIBLE TO KNOW THE TERMS OF MY INSURANCE COMPANY'S PHYSICAL THERAPY BENEFIT AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY MY INSURANCE.**

______ **(Please Initial)** Appointments should be scheduled, changed, or canceled at least 24 hours in advance. **THERE IS A $35.00 CHARGE FOR MISSED APPOINTMENTS WITHOUT GIVING 24-HOUR NOTICE.** This charge is the patient's responsibility and cannot be billed to the insurance company. The prescribed treatment plan must be followed to maximize the effectiveness of the treatment. If more than three appointments are missed without notification, care may be discontinued.

______ **(Please Initial) ANY APPOINTMENT MISSED BY MORE THAN 15 MINUTES MAY BE CANCELLED AT THE CLINICIAN'S DISCRETION TO AVOID INTERFERING WITH ANOTHER PATIENT'S SCHEDULED APPOINTMENT.**

______ **(Please Initial) COPAYMENTS, SELF-PAYMENTS, AND SUPPLY COSTS ARE DUE AT THE TIME OF YOUR VISIT.**

All patient's financial obligations to Boston Sports Medicine, Inc. must be paid no later than thirty (30) days after the first invoice is mailed. It is your responsibility to notify Boston Sports Medicine, Inc. of any change in address. ANY PATIENT BALANCES OWED BEYOND THIRTY (30) DAYS WILL ACCRUE 1.5% PER MONTH, 18% PER ANNUM INTEREST. COLLECTION AGENCY COSTS OF UP TO 50% OF THE BALANCE OWED WILL BE YOUR RESPONSIBILITY. Failure to receive invoices due to an address change that was not communicated to Boston Sports Medicine, Inc. will not excuse interest charges or collection costs.

BY SIGNING BELOW, I STATE THAT:

- I consent to treatment that will be provided to me at Boston Sports Medicine and understand that I may refuse to continue care at any time for any reason.
- I understand the policies stated above.
- I understand that Boston Sports Medicine, Inc. may disclose my protected health information without my consent only in order to carry out treatment, payment, or healthcare operations. I acknowledge the receipt of a copy of the Notice of Information Practices.

Signature: ____________________________________ **Today's Date:** _______________