BACKWORKS
PHYSICAL THERAPY

2445 Dean Street Unit B, St. Charles, IL 60175 **T** 630.513.2700 **F** 630.513.2703

**OUR FINANCIAL POLICY**
Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy that we require you to read and sign prior to any treatment.

**REGARDING INSURANCE**
We will be happy to bill your primary insurance carrier. Please note that your insurance policy is your responsibility. This includes being aware of what your benefits are for physical therapy as well as any limitations on your coverage. This includes pre-certification. You are also responsible for making sure your insurance company processes your claims and pays your bills in a timely manner. In the event of a late payment, you will be liable to BACKWORKS, LTD. for all costs incurred by BACKWORKS, LTD. in collecting your account, including but not limited to attorneys fees and court costs. You will also be charged interest at the rate of 1% per month (12% per annum) on balances outstanding for more than 30 days. If this is a workman's compensation claim, we will check with your adjuster to authorize treatment according to your doctor's orders. You are still responsible for any disputed claims. A quote of benefits is not a guarantee of payment. You are responsible for payment of your portion. If we are in network with your insurance company, we will take any necessary adjustments and you will be responsible for your portion in full. We will be happy to make payment arrangements with you. Our practice is committed to providing the best treatment for our patients. Therefore, we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Fees are based on treatments received and have no bearing on outcomes. Adult patients are responsible for their own payment of service. The adult accompanying a minor will be responsible for payment. Any minor not accompanied by an adult will be denied treatment unless payment arrangements are made and consent forms are signed in full.

**MISSED APPOINTMENTS**
Unless cancelled within 24 hours of an appointment time, our policy is to charge for the missed appointment at the rate of a normal visit. Please help us to serve you better by keeping scheduled appointments.

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

With my consent, BACKWORKS, LTD may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to BACKWORKS, LTD's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. BACKWORKS, LTD reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to BACKWORKS, LTD's Privacy Officer at 2445 Dean St, Unit B St. Charles IL 60175. With my consent, BACKWORKS, LTD may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. BACKWORKS, LTD may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as patient statements, collection letters and any other correspondence or related material. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to BACKWORKS, LTD to use and discloser of my PHI to carry out TPO. I am also consenting BACKWORKS, LTD to communicate all pertinent information between them and my referring physician.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. If I do not sign this consent, BACKWORKS, LTD may decline treatment to me.

I hereby authorize BACKWORKS, LTD. to release any information necessary to process my insurance claims. I authorize the payments of my insurance benefits to be made to the provider of services. I have read this financial policy. I understand and agree to this financial policy.

Signature of patient or parent/guardian:_____

Print Name:_____ Date:_____