

PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing Knight Medical & Rehab Center, Ltd. d/b/a The Knight Center for Integrated Health for your healthcare needs. As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance or co-payment amounts prior to any visit. Not all services are covered in all insurance contracts. As a result, some procedures we feel are medically necessary for optimal treatment or preventative care may not be covered by some plans. Due to the differences in various insurance plans and programs, we cannot guarantee that services provided by our practice will be covered under your insurance policy. In addition, our practice may not have a preferred provider agreement with your insurance company. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges. It is your sole responsibility to know and determine what medical procedures your policy includes and excludes including specialists, hospitals, lab tests, x-ray facilities and other medical facilities that are accepted and covered by your insurance plan. In circumstances where your insurance company determines that past payments on your behalf for services rendered were made in error and your insurance company attempt to recoup said payments by withholding that amount from future payments or using collection agencies, you will be responsible for the amount sought or withheld. To find out what your insurance plan covers and what your financial obligation may be, call the member services department listed on your insurance card. Your employer's human resources department may also be a source of information and assistance.

For the convenience of our patients we accept cash, Visa, Master Card, Discover, traveler's checks, Money Orders and personal checks. Co-payments, co-insurance and deductibles required by individual insurance plans are due at the time services are rendered. Patients without insurance are expected to assume full financial responsibility for all medical services provided. If, for any reason, full payment cannot be made at the time of service, please contact our office to determine if a reasonable payment arrangement can be established. At the discretion of Knight Medical & Rehab, Ltd., future services may be denied until account balances are brought current.

In order to be respectful of the medical needs of others we require a 24 hour advance notice of any cancellations. Failure to comply may result in a cancellation fee. Recurring instances may lead to your dismissal as a patient of The Knight Center for Integrated Health.

We accept Medicare assignment of covered charges. Patients will be billed for co-insurance, annual deductibles or any uncovered charges unless the patient has supplemental insurance.

Workman's Compensation cases require prior authorization from either the employer or insurance carrier agent before treatment. Should the employer or insurance carrier subsequently deny validated worker's compensation service, such charges will become the financial responsibility for the patient and subject to the terms and conditions outlined in the preceding paragraphs.

In cases of personal injury, we do not defer payment until settlement or judgment. Any patient treated in relation to a personal injury case will be expected to assume full financial responsibility under the terms and conditions outlined in the preceding paragraphs. Claims will be submitted to your insurance company and you will be charged the usual co-payments, co-insurance and deductibles. It will be your responsibility to seek personal reimbursement from the sources you feel are responsible. In the case where your health insurance company denies such claims you will be responsible for full payment for all services rendered.

RELEASE

I have read the policy regarding my financial responsibility to Knight Medical & Rehab Center, Ltd. I hereby certify that all information I have provided is accurate and true. I authorize payment of any benefits directly to Knight Medical and Rehab Center, Ltd. for all services rendered. In the event that my health plan determines services as not covered, I will be liable for all charges. I agree to be responsible for payment of all unpaid services rendered on my behalf or behalf of the above named patients including any collection fees, attorney's fees or court costs incurred through efforts to collect payment for such charges.

I request that payment of authorized Medicare benefits, if applicable, be made on my behalf to Knight Medical & Rehab Center, Ltd. for services rendered to me by my provider. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

PATIENT/GUARDIAN SIGNATURE _____ DATE ____/____/____