Consent for Treatment
Acknowledgment of Financial Responsibility

# Complete Home Therapy

*"Therapy where you need it most"*

Outpatient therapy services are billed under the Medicare Fee Schedule. If you are covered under Medicare, Medicare will pay for reimbursable charges of our services at 80% of the covered amount. We will bill your co-insurance, or we will bill you, for the 20%. If you are covered under a different insurance policy, a copy of our Insurance Verification will be provided to you so that you are aware of the projected out of pocket expense. However, please know that verification of coverage is not an authorization for payment. We will be happy to bill your insurance company on your behalf, however, if for any reason your insurance company does not pay, the charges are your responsibility.

**INSURANCE BENEFITS:**

- I certify that my primary insurance is _____
- I certify that my secondary insurance is _____

_____ I understand that Complete Home Therapy has verified that Medicare is PRIMARY and will reimburse the intial 80%.

I understand that it is my reponsibility to verify the reimbursement details of my secondary insurance. Complete Home Therapy does not verify if my supplemental insurance will pay the remaining 20% in full or a portion of the 20%. I will be resonsible for any
_____ co-pay, co-insurance, or deductible.

**FINANCIAL ACKNOWLEDGMENT:**

- I acknowledge that any change to my primary or secondary insurance could affect my financial responsibility and that I will **immediately** notify Complete Home Therapy about the change to my primary or secondary insurance.
- I authorize payment directly to COMPLETE HOME THERAPY due me in my pending claim and/or major medical benefits otherwise payable to me, not to exceed the charges for this period of treatment.
- I understand that if payment is issued directly to me, it is my responsibility to forward this payment to Complete Home Therapy.
- Should this account go delinquent, I agree to pay all costs of collection including collection agency fees, court costs and attorney fees.

**PATIENT CONFIRMATION & CONSENT:**

- I certify that I am not currently receiving any services from a home health agency or outpatient rehabilitation facility. If I purposely deceive Complete Home Therapy of this, then I may be held responsible for paymnets for services.
- I confirm that prior to starting any home health services, I will notify COMPLETE HOME THERAPY.
- I confirm that I will notify COMPLETE HOME THERAPY of any change to my primary or secondary insurance provider.
- I consent to treatment and to participation in this rehabilitation program.

**CANCELLATION POLICY:**

I will give Complete Home Therapy at least 12 hours notice if I need to cancel a previously scheduled appointment.
_____ Cancelling within 12 hours/no show will result in a $50.00 cancellation fee.

***Please check box if applicable:***

☐ **I have a Power of Attorney (POA) for financial decisions.** (Verbal acknowledgment of financial responsibility is required from the POA prior to evaluation for a patient who is competent, but has deferred financial decisions to a POA.)

☐ **I am the POA for this legally incompetent patient. (**A COPY OF ANY APPLICABLE POA DOCUMENTS MUST BE PROVIDED FOR THE PATIENT'S RECORD PRIOR TO EVALUATION.)

_____

Patient Name (Print) Signature Date

_____

Other Responsible Party (Print) Signature Date