



LATTIMORE PHYSICAL THERAPY
AND SPORTS REHABILITATION NETWORK

FINANCIAL POLICY AND RELEASE OF INFORMATION AUTHORIZATION

Payment is expected at the time of services are rendered or at the end of each week unless specific credit arrangements are made in advance.

Patients with Medicare: Claims will be submitted to Medicare on the patient's behalf. Patients are responsible for an annual \$135 deductible and 20% coinsurance. Payment for non-covered services are due at the time this service is performed. A claim will be sent to your supplemental insurance when information is provided by the patient. **If a balance remains after insurance(s) have reviewed and made any payment on claims, you will then become responsible for that final payment.**

Patients with Insurance: Patients are responsible for deductibles, copayment, non-covered service, coinsurance, and items considered "not medically necessary" by the insurance company. A claim will be submitted to the insurance company when LATTIMORE PHYSICAL THERAPY AND SPORTS REHABILITATION NETWORK is provided with the necessary billing information. Any remaining balance is due from the patient within a timely manner. **If a patient or an insurance carrier pays an amount exceeding the balance, a refund will be issued to the appropriate party.**

*** **HMO copayments are to be paid at time of service or at the end of each week.**

*** **We do not accept Medicaid as primary or secondary insurance. You will be responsible for any balances if you do not inform us that you have Medicaid.**

MESSAGE AUTHORIZATION

I hereby authorize LATTIMORE PHYSICAL THERAPY AND SPORTS REHABILITATION NETWORK to disclose a verbal message pertaining to my appointments to a family member or by leaving a message on my home or cell phone answering machine.

RELEASE OF INFORMATION

I authorize LATTIMORE PHYSICAL THERAPY AND SPORTS REHABILITATION NETWORK to release to the referring physician and/or my primary care physician (PCP), medical vendor, insurance carrier and/or it's agents the necessary information pertaining to my treatment as requested to expedite claim processing/payment and/or further authorization for treatment and/or medical equipment.

ASSIGNMENT

I request that payment for authorized benefits with Medicare and/or my insurance carrier be made on my behalf to LATTIMORE PHYSICAL THERAPY AND SPORTS REHABILITATION NETWORK.

I have read and agreed to the Credit Policy, Release of Information, and Assignment statements above that apply to me.

X _____
Patient or Responsible Party Signature

Date

Lattimore Physical Therapy 1655 Elmwood Ave. Ste. 130 Rochester, NY 14620 585-442-9110	Lattimore at White Spruce Physical Therapy 383 White Spruce Blvd Rochester, NY 14623 585-442-6067	North Greece Physical Therapy 515 Long Pond Rd. Rochester, NY 14612 585227-2310	Hilton Physical Therapy 1026 Hilton-Parma Rd. Hilton, NY 14468 585-392-8001	Piano Works Physical Therapy 349 W Commercial Ste 1275 East Rochester, NY 14445 585-264-0370
Pittsford-Mendon Physical Therapy 20 Assembly Dr, Ste 101 Mendon, NY 14506 585-582-1330	Honeoye Falls/Lima Physical Therapy 58 North Main St Honeoye Falls, NY 14472 585-582-0034	Lattimore of Rush Henrietta Physical Therapy 20 Finn Rd Ste. A Henrietta, 14467 585-444-0040	Lattimore of Webster Physical Therapy 1130 Crosspointe Ln Ste 6 Webster, NY 14580 585-347-4990	Lattimore of Irondequoit Physical Therapy 1299 Portland Ave. Suite 10 Rochester, NY 14621 585-227-2310
Fairport Physical Therapy 59 Perinton Hills Shopping Center Fairport, NY 14450 585-385-0444				