140 S Beach Suite 310, Daytona Beach FL 32114
Email: assistant@thehopegroup4.com P.386.898.6040 F.386.256.2320

Patient Responsibility Agreement

We bill all insurance payers although we may not be contracted with all insurance companies. If we are a network provider for your insurance company, they will pay for our services at the negotiated rate and we will apply the appropriate payments and adjustments to your account. It is your responsibility to pay deductibles, copayments or coinsurances. All out of network charges will be negotiated as discussed per this agreement.
If pre-authorization is required, it is the responsibility of the provider to initiate the authorization process. If the authorization is not approved at the time of your evaluation, you will be given the option to have the evaluation without authorization and risk denial and financial responsibility or reschedule until authorization is approved. Upon the completion of your evaluation, we will bill your insurance.

Definitions
Deductible- The deductible amount depends upon the type of plan that you have with your insurance carrier. This is the amount that must be paid by you prior to your insurance making any payments on your behalf.
Copayment- is a predetermined fee an individual will pay for health care services, in addition to what the insurance covers. For example, some insurance payors require a $10 copayment for each office visit, regardless of the type or level of services provided during the visit.
Coinsurance-is a predetermined percentage an individual will pay for health care services, in addition to what the insurance covers. For example, some insurance requires a 20% coinsurance. We will bill your insurance and apply all payments and adjustments. You will be responsible for the 20% that your insurance does not cover.
We have determined the following to be your responsibility per the phone call to your insurance company. THIS IS NOT A GUARANTEE OF PAYMENT.

Patient Acknowledgement: _____ _____
Print Name Date

By signing below, I acknowledge and consent to the following, where applicable:

1. Medical Consent: I authorize Hope Harbor Therapies to perform physical therapy assessment and treatment which will be discussed with my therapist.
2. Payment of Services: I understand that payment is expected at the time of service, and I am fully responsible for all fees that are not covered by my insurance except those prohibited by the insurance carrier. Insurance will be filed for services rendered as directed by me. Co-pays and Co-insurance are expected at the time of service.
3. Cancellation Policy: We require 24 hours' notice in the event of a cancellation. There is a $25.00 Charge for a cancellation without proper notice. This charge will not be covered by insurance, and you will be responsible for this charge personally. We review any emergencies, illness & discuss on a case by

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case basis to determine any justification to waive this fee.
4. Notice of Privacy Practices: By way of signature, I provide Hope Harbor Therapies, LLC with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and healthcare operations as described in the Privacy Notice.
5. Medical Insurance Benefits†: Hope Harbor Therapies will verify my insurance coverage prior to service and filing clams. Based on this information Hope Harbor Therapies will estimate the portion of charges for which I should be responsible, taking into consideration coordination of secondary insurance if primary insurance is a traditional Medicare policy.
6. Change of Insurance: I understand that I am to inform Hope Harbor Therapies if my insurance changes during treatment. If your claims are returned due to termination of your insurance, you will be responsible for full bill.
7. Medical Records Release: I authorize Hope Harbor Therapies to release my medical records to any referring physician, insurance company, health care facility or government agency requesting such information.

I authorize the release of any medical information to the following person:

Name: _____ Relationship: _____

Patient Acknowledgement

_____	_____	_____
Printed Name	Signature	Date