448 21st Street West, Ste D1,
Dickinson, ND 58601
701.483.1000

PATIENT AGREEMENT & RESPONSIBILITIES

Insurance
As a patient of Therapy Solutions, you will be asked to provide us with the following information regarding insurance coverage:

1. Name of insurance carrier
2. Name of policy holder or subscriber of insurance
3. Policy number, group number, and social security number (if applicable)
4. Name, address, and phone number of the insurance company

This information must be provided along with a copy of your insurance card at patient's first appointment. If you do not have the necessary information, you will be **Self-Pay** until the information is provided.

Self-Pay
Therapy Solutions designates accounts, Self-Pay, under the following circumstances: (1) patient is covered by an insurance plan that our providers do not participate in, (2) patient does not have a current, valid insurance on file and has failed to provide one that day, (3) patient does not have a valid insurance referral on file, or (4) patient does not have health insurance coverage. Payment is required at the time of service.

Referrals
If your insurance plan has a designated primary care physician and you are required to obtain a written referral from that doctor, you must provide that referral at the time of **check-in** or have the referral faxed to the office prior to the first visit. If at the time of check-in you do not have a current, valid referral, we may ask you to either reschedule your appointment or pay for the visit at the time of service.

Financial Responsibility
- The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of fees. Therapy Solutions will verify your health insurance coverage and bill your insurance carrier on your behalf. However, you (or patient's guardian, if a minor) are ultimately responsible for payment of your bill.
- Inform Therapy Solutions of any changes in insurance, address, or phone numbers for the patient and the responsible party. The patient will be responsible for any charges incurred if the information provided is not correct or updated.
- Patients are responsible for the payment of copays, coinsurance, deductibles and all other procedures or treatments not covered by their insurance plan. **Copays are due at the time of service.** We accept cash, check and most major credit cards at our office.
- Patients may incur and are responsible for the payment of additional charges at the discretion of Therapy Solutions. These charges may include, but are not limited to:
  - Charges for returned checks.
  - Any costs associated with collection of patient balances.
- Any balance under $100 must be paid in full within **30 days** of billing. Balances greater than $100 either need to be paid in full, or in four equal monthly payments. If you cannot meet these guidelines, contact our billing office to make alternative payment arrangements. If payment is not received within 30 days of billing or payment arrangements have not been made, further collection activity will occur, including the balance being turned over to Dickinson Credit Services, Inc.

Consent for Care & Policy Disclosure
I do hereby give my consent for Therapy Solutions to perform any therapeutic procedure or treatment considered in the evaluation and treatment as described to me or as my physician or therapist determines are necessary and consistent with my diagnosis. I understand I have an opportunity to ask questions regarding my treatment and that my therapist will be available to answer any questions. I understand I may terminate any treatment at any time.

Assignment of Benefits & Release of Information
I hereby assign all medical benefits to which I am entitled, to include any major medical, private insurance and third party payers to Therapy Solutions. A photocopy of this assignment is to be considered as valid as the original. I am responsible for understanding my insurance coverage. I hereby authorize Therapy Solutions to release all information necessary, including medical records to secure payment. I understand that I am financially responsible for all charges not covered by my insurance or other third party payers and that the balance after insurance or third party payment has been made is due within thirty (30) days. I agree to contact my insurance carrier to find out if my treatment is covered and to take such steps as requited to qualify my treatment for coverage. I agree to inform Therapy Solutions of any changes in my insurance.I authorize payment directly to Therapy Solutions for services rendered.

Payment Guarantee
As a courtesy, Therapy Solutions, verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received. It is the policy of Therapy Solutions that payment is due at the time of service unless other financial arrangements are made in advance. At the conclusion of your visits with us you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly. Please remember you are responsible for all charges incurred; your physician's referral and our verification of your insurance benefits are not a guarantee of payment. We highly recommend you also contact your insurance carrier and check into your coverage.

Notice of Privacy Practices
I acknowledge that I have read through the ***Notice of Privacy Practices*** from Therapy Solutions. I understand that my protected health information may be used as described in the notice. I have been notified I have the right to request a copy of the *Notice of Privacy Practices.*

Patient Authorization
By signing below, you agree to accept full financial responsibility as a patient who is receiving services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities and agree to these terms.

I have read, understand and agree to the provisions of this form:

Patient's Signature **Date**

Patient Name (Print) **DOB**

Guardian/Power of Attorney **Date**
(if minor or adult unable to sign)