# Northern Arizona Rehabilitation & Fitness, PC
# Financial Policy

FOR ALL PATIENTS: Please be assured that your health is our primary concern. The following office policies are outlined for your benefit in order to avoid possible areas of confusion. The office personnel are available to assist you if you have any questions.

Northern Arizona Rehabilitation & Fitness, PC accepts assignment for Medicare. If your insurance plan has a co-payment, co-insurance or a deductible that has not been fulfilled, the payment of the co-payment, co-insurance and/or the amount of the remaining deductible is due at the time of service.

As a courtesy to you, this office will bill your insurance. We will also bill your Medicare secondary insurance if applicable. However, any and all charges not covered by your insurance(s) are due and payable without delay, unless prior arrangements are made with this office.

Our office will also verify the presence of insurance coverage on your primary insurance; however, you are responsible for knowing the benefits and restrictions of your insurance policy. At your request, we will assist you with obtaining pre-certification or pre-authorization required by your insurance.

Any special requirements for services, pre-certification for services, or pre-authorization are ultimately your responsibility.

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I have read and understand the above Financial Policy and hereby acknowledge that any and all medical bills, collection fees on my account, or lawyer's fees incurred due to my delinquent payments are my personal responsibility.

I hereby authorize Northern Arizona Rehabilitation & Fitness to perform rehabilitation services to myself/child and authorize them to release my therapy records (including my evaluations, treatment records and progress notes to my physician, insurance carrier, and/or other named institutions).

I authorize payments of medical benefits to Northern Arizona Rehabilitation & Fitness for any medical care rendered to myself or to my dependents. I understand that I am responsible for any amount not covered by my insurance.

I acknowledge all of my patient information is complete and true. I also understand that overdue balances may incur additional charges. I will bear the cost of collection and/or court costs/legal fees should this be required.

Signature: ______________________________________________ Date: ___________________

Witness: _______________________________________________ Date: ___________________

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Emergency Contact Information

Name: __________________________________________________ Telephone: ________________________

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