AFFILIATED HEALTH OF WISCONSIN
PAIN REHABILITATION ASSOCIATES – PHYSICAL THERAPY
Financial Policy

updated 12/2018

Patient's Name: _____ Date of Birth: _____

Affiliated Health of WI, Ltd. (AH) maintains personnel and facilities to assist physicians as they perform various medical, diagnostic or therapeutic procedures. Drs. Gorelick and Tolentino are not agents, servants or employees of the facility, but independent contractors and therefore are the patient's agents or servants. AH provides support services (including Physical Therapy) and facilities; AH does not provide medical physician care.

Billing and Financial Policy:

A copy of your insurance card is required at each visit. If you do not have your insurance card(s), you may be asked to pay for all services. I understand that Affiliated Health of WI, Ltd. (AH) will submit my charges to my insurance company for services, provided they have complete insurance information. I understand and have been notified in advance that Drs. Gorelick, Tolentino and Jeanne Denk NP-C at Pain Rehabilitation Associates are NOT Medicaid providers. I agree to accept responsibility for payment of these non-covered services. I understand that Dr. Jeffrey Gorelick is a non-participant in the Medicare program and rendered services will not be billable to those programs. It is my responsibility to notify AH of any changes in my healthcare coverage. I understand and I agree that I am financially responsible to AH for any charges not covered by my healthcare benefits, including all co-pays, co-insurance and deductibles. I am responsible for the entire bill or balance of the bill as determined by AH and/or my healthcare insurer if the submitted claims or any part of them are denied for payment or if the submitted claim(s) are processed as not medically necessary by my healthcare insurer.

I understand that my health insurance company does not guarantee benefits. Services rendered by the TMJ and Orofacial Pain Treatment Centers of WI/LMG, Inc. are billed separately and not included in your AH billing. For your convenience, however, AH reserves the right to apply patient payments between corporations (LMG, Inc. /Affiliated Health of Wisconsin, Ltd.) unless otherwise requested in writing from you.

Missed Appointments:

Unless cancelled at least 24 hours in advance, our policy is to charge for the missed appointments at the rate of a normal office visit. This is billed directly to you, the patient. Insurance companies do not cover missed appointments. In addition, if only part of the treatment could be provided because you were late for your appointment, you will be billed for the scheduled treatment.

Special Ordered Supplies: All special ordered merchandise or supplies must be paid for in full prior to ordering.

Return Policy: All sales are final.

Medical Consent:

I, the undersigned, hereby consent to medical care including, but not limited to: examination, X-rays, medical and physical therapy treatments, injections, administration of medications and modalities, as are, in the judgment of the treating practitioner, medically advisable for the patient identified above. I understand that no guarantee has been made as to the results of the care, treatment and medications of the patient.

I have read and I understand and agree with this financial policy. I guarantee payment of all charges incurred for this account. I further agree that Affiliated Health of WI may reschedule my appointment should I refuse to make payment required by this agreement. I further agree to pay any attorney fees, court costs, and related fees incurred. I also understand that benefits discussed in the office are not a guarantee of payment by my insurance company. This authorization is in effect until I choose to revoke it in writing.

_____ _____

Signature of Patient/ Parent/Guardian/Personal Representative Date

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For Minor Patients Only:

Law states the parent/ guardian / personal representative or other legal authority seeking or authorizing medical treatment is responsible for paying the bills. If payment for services is to be paid by someone else, then the parent, guardian or personal representative bringing the child for services must pay and have the other party reimburse them.

I, _____ hereby authorize and consent to the performance of examinations, procedures and treatments
Name of Parent/Guardian/Personal Representative/other Legal Authority

for _____, which the physician may deem necessary.
(Patient's name)

This consent shall remain in effect until I choose to revoke it in writing.

_____ _____

Signature of Parent/Guardian/Personal Representative/other Legal Authority Date

_____

Description of Parent/Guardian/Personal Representative/other Legal Authority