Financial and Reimbursement Policy:

Insurance:

• Unified Therapy Services, Inc. (UTS) participates in most insurance plans. UTS will bill the patient's insurance company as a courtesy.

• A current copy of your valid insurance card and insurance holder's photo I.D./Driver's License is necessary to confirm proof of insurance.

• UTS will not be responsible for supplying and sending to your insurance company any information that does not relate to UTS (e.g., coordination of benefits information, etc.). It is the responsibility of the patient to comply with the insurance company's request.

• The patient is directly responsible for the balance of their claim whether their insurance company pays the claim or not. The patient's insurance benefit is a contract between the patient and the insurance carrier; UTS is NOT a party to that contract.

• If a claim has been denied and is going through the appeals process, UTS will appeal one time. After that the claim will be converted to the UTS Private Pay rate. It will then be up to the patient to appeal with their insurance directly.

• If you change insurance plans while receiving treatment with UTS, we must be notified and given a copy (front and back) of the new card on or before the first day of your new plan. Non-adherence to this will result in full patient responsibility until UTS receives new plan and checks benefits.

Referrals and Checking Benefits:

• As a courtesy, UTS will call your insurance company to check benefits prior to services. However, it is very important to understand that the information the insurance company provides UTS is NOT a guarantee of payment as benefits are subject to all contract limits and the member's status on the date of service.

• Accumulated amounts such as deductibles may change as additional claims are processed. We will do our best to help you maximize your insurance reimbursement; however, claim coverage is not guaranteed. Our Billing Specialist is available to answer any questions and explain coverage. It is also strongly recommended that you call your insurance company to familiarize yourself with, and have the insurance company help explain, your specific benefits.

• Your insurance company may initially state that they cover services. However, as stated above, this is not a guarantee, and they may deny services at any time. As a courtesy, UTS will make up to TWO attempts (one initial claim and one appeal) to submit the patient's bill for services to your insurance company. After two attempts, you will be financially responsible for any charges denied by your insurance company. UTS will charge you for all services requested and rendered, and you are responsible for your balance.

Co-Payments, Deductibles, Co-Insurance, and Balances:

• Any patient responsibility will be due upon receipt of services. The payment will be automatically charged to your payment method on file (pursuant to the "Credit Card File Agreement").

• Any outstanding patient responsibility will be billed monthly. If no payment is made by the 28th of the month, the payment will be automatically charged to your payment method on file (pursuant to the "Credit Card File Agreement"), up to $100 per month.

Nonpayment

• If the patient's account is 90 days past due or greater, and the balance is not immediately paid in full or a payment arrangement made, the account may be sent to collection. Until balances are paid in full, or a payment plan has been made, therapists will treat the patient only on an emergency basis. Patients may be discharged due to non-payment.

Divorce/Separation:

• In the case of a divorce or separation, the party responsible for the account balance is the parent/guardian authorizing treatment for the child. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Payment Options & Credit Balance Refunds:

• UTS accepts payments by cash, check, VISA, MasterCard, Discover, and American Express.

• UTS will make a good faith effort to capture all accounts that have been overpaid by a patient or insurance carrier and to refund the appropriate party within a reasonable time frame. A refund will be issued only under the following circumstances:

- A patient paid more than was required based on their contractual agreement with their insurance carrier, and there is no other outstanding balance due by that patient to which the credits can be applied.
- A patient or insurance carrier erroneously issued a duplicate payment.
- The payer erroneously remits payment to the wrong provider.
- The payer originally remits payment for a service that is later determined to be a non-covered service. In this situation, a refund may need to be issued to the payer, and a bill issued to the patient if said non-covered services is deemed by their insurance to be a patient responsibility.
- The patient paid an assessed co-pay/co-insurance/deductible and it was later determined that a secondary insurance was responsible for this balance.

• Refunds will not be issued when:

- Insurance is pending payment
- There is a pre-existing balance due on the patient's account

Financial Assistance

• Unified Therapy Services understands that certain situations may arise and cause financial hardship. UTS is committed to providing optimal care for our patients regardless of financial status. If you are having difficulties or are unable to pay for the pre- determined rate of services, co-payments, and/or deductibles please ask the Patient Care Coordinator at your clinic for information on Grants that may be available to our patients. Each situation will be reviewed on a case-by-case basis.

No-call/No-show

- If the patient fails to present to the appointment at the scheduled time or fails to call ahead of time and cancel/reschedule their appointment, we will record the visit as a "no-show".
- We will bill a fee billed to the patient, not the insurance company, as they see this as the patient's responsibility.
  - The No Call No Show fee for standard visits will be $10.00.
  - The No Call No Show fee for Feeding Therapy will be $20.00 due to the cost associated with prepping food for feeding appointments.
  - The No Call No Show fee for Wheelchair Evaluations will be $25.00 due to the length of the visit.
  - The No Call No Show fee for FCE visits will be $75.00 due to the length of visit and prep required for the visit.

UNIFIED Therapy Services

Card on File Agreement

Unified Therapy Services Inc ("UTS") requires a payment method (credit, debit, or HSA card) to be on file. UTS takes your payment information very seriously and makes sure that it is stored in a HIPAA compliant manner and only the very necessary people have access to it.

Cards on File will be used for:

(1) Co-Pays, Co-Insurance, Private pay, and Deductible

UTS will automatically charge your card on file for all applicable patient responsibility, including no-call/no-show fees, on the date services are provided.

(2) Balances

If your insurance carrier assigns any additional patient responsibility amounts, we will run the Card on file for this amount not to exceed $100.00 per month, until patient balance is $0.00. If a payment is made prior to the 28th of the month the card on file will not be charged.

(3) Discharge

Card on file will be charged up to $100.00 per month after discharge until patient balance is $0.00. If a payment is made prior to the 28th of the month the card on file will not be charged.

For all patient responsibility amounts assigned by the insurance company, our office attempts to review these amounts to ensure your claim has been properly adjudicated. If what is adjudicated by the insurance company does not match the benefits we verified with the insurance company at the time of service, we will contact you and your insurance carrier. However, UTS makes no guarantees as to the adjudication of any insurance matters and is not responsible for advocating on your behalf your disagreement with the insurance company regarding patient responsibility.

Members will typically receive their explanation of benefits prior to the provider, so if you disagree with the patient responsibility amount owed; it is solely your responsibility to contact your insurance carrier immediately.

Please note the following:

- Your signature below indicates your agreement and consent to these charges being placed on your card on file.
- At the time of payment in the office, you may still need to occasionally present your card for payment, even if the card is on file.
- During the time you leave a card on file, if it expires or otherwise becomes uncollectible, we will expect you to promptly provide a new means of payment. Failure to timely pay past due balances will be addressed based on the terms of UTS's Financial & Reimbursement Policies.
- Unified Therapy sends out paperless patient statements, yours will be sent to the email listed below (page 4).

I authorize Unified Therapy Services, Inc to run my card on file for the purpose(s) stated above and per the terms of this agreement. This authorization will remain in effect until I give written notice to Unified Therapy to change or terminate this authorization.

I have read and understand the above financial policy and agree to the terms and conditions set forth therein. I have also received a copy for my records.

Patient Name: _____

Patient Signature (if over 18 years old): _____ Date: _____

*Parent/Guardian Name: _____

*Parent/Guardian Signature: _____ Date: _____

**Note: A Parent/Guardian name and signature is required for all patients under the age of 18. Additionally, patients who are 18 years of age and over must also have UTS forms signed by a Parent/Guardian where the patient continues to be under their family's medical insurance policy, and/or where a Parent/Guardian has been declared the guardian of an adult by a court of law.*

Credit Card Information:

Please indicate type of Credit/Debit/HSA Card: Visa Master Card Discover

Name on Card: _____ Card Number: _____

Expiration Date: _____ 3-Digit Security Code (found on back of card): _____

Billing address of credit card (if different from patient address): _____

Receipts are provided via email. Please provide email address: _____

Refusal:

I understand by refusing to have a card on file, I will be required to pay via cash, check or card at each appointment or services will be placed on hold until my account is in good financial standing. In addition, I will pay my monthly statement in full up to $100.00 each month.

Initials: _____