Treatment and Payment Policy

Thank you for choosing Cornerstone Therapy Associates (Cornerstone) for your occupational therapy services. We believe that there should be a clear understanding between the therapist and patient as to their rights and responsibilities. Please review and sign the following Treatment and Payment Policy prior to beginning services. If you have questions, please do not hesitate to ask for clarification.

Treatment

You will have the opportunity to discuss the benefits of the proposed procedures and therapeutic courses of treatment with the therapist to your satisfaction.

You have the right to consent or refuse any proposed therapeutic course of treatment.

Subject to the foregoing, the therapist may administer any therapeutic procedure deemed advisable to your care and treatment.

Services

Cornerstone Therapy Associates provides detailed performance and sensory evaluations as part of our service. A typical evaluation can range between one to six hours of direct assessment/observation and consultations from which reports are generated, some of which could include:

Performance evaluation 1 – 1.5 hours
Sensory Profile 1 – 1.5 hours
School Sensory Profile 1 – 1.5 hours
School Function Assessment 1 – 1.5 hours

It is our policy that **evaluations are not billed through insurance** and will be billed directly to the client. The hourly cost for evaluations is $100 an hour. Regular OT sessions will be billed through insurance, if it is an insurance carrier we accept. For any insurances that we do not accept, services will be charged through our self-pay process, which is also $100 an hour.

We currently file claims to the following insurance carriers only:

Anthem (We do **not** accept the Healthkeepers branch of Anthem)

Cancellations or Missed Appointments

Cancellations or rescheduling requests with less than 24 hours' notice may result in a cancellation fee of $50 charged to your account. We do consider exceptions for unavoidable emergencies on a case-by-case basis.

Frequent cancellations and/or missed appointments (no show) may result in a reduction of scheduled sessions.

Payments

Cornerstone is a private facility which relies solely on income from patients and their insurers. In order to provide the best possible therapy care at the lowest possible cost, we need your assistance and agreement to the following policy.

By signing this document, you agree to assign to Cornerstone any and all health care benefits to which you are entitled under any policy of insurance and authorize to the extent permitted by law, payment of those benefits directly to Cornerstone. We will protect the privacy of your health information and will not use it or disclose it except in a manner that is permitted by state and federal law. By signing this document, you consent to our use and disclosure of your health information in accordance with the

Notice of Privacy Policies and applicable law.

If you have health care benefits that are covered by Cornerstone, we will submit a claim to your insurance company on your behalf. However, you are required and agree to pay at the time of service, any required copayments, coinsurance and deductibles, as well as charges for services not covered by insurance, outstanding balances and delinquent accounts. We will accept checks, cash, or electronic payment for therapy services.

If you do not have health care benefits or have insurance by which Cornerstone is not a network provider, you are required and you agree to pay at the time of service all charges as well as any outstanding balances and delinquent accounts.

If Cornerstone has not received a response on a claim from your insurance company within 60 days of having filed a claim for a visit, we will assume that the visit is not covered and is, therefore, your responsibility. At that time, to the extent permitted by law, we will bill you for these charges. Questions regarding nonpayment by your insurance company should be directed to your insurance company.

By signing this document, you agree that you have been advised that your insurance company may determine that services provided by Cornerstone during your visit are not covered under your insurance policy and agree that, if your insurance company determines that any services are not covered, you shall be responsible for and shall pay the cost of any such services. Initial: _____

In the event that your plan requires approval or referral from your Primary Care Physician or insurer prior to a visit and you did not obtain that approval or referral, you will be responsible for and agree to pay any costs of care that your insurance company determines are not covered under your insurance policy and for which you may be held liable under applicable law. Initial:_____

You will be billed monthly for all unpaid balances deemed by Cornerstone or your insurance company to be your responsibility. You are responsible for paying the bill in full unless special arrangements have been made in advance. A Late Fee of $10 per week will be applied on balances that are still unpaid after 14 days of receiving your invoice. There is a fee of $20 for returned checks. Delinquent accounts may be turned over to a collection agency at which time you agree to be responsible for collection charges and all associated legal fees in addition to the amount owed.

I have read, understand and agree to the Treatment and Payment Policy as described above and understand that Cornerstone Therapy Associates may refuse treatment if I do not remain current in payments for therapy services.

_____	_____	_____
Patient or Guarantor Name (print)	Patient or Guarantor Signature	Date
_____	_____	_____
Minor Patient's Name	Relationship to Guarantor	Date

The terms "you and your" in this policy are the patient and the patient's guarantor, if applicable. A guarantor is the individual who accepts financial responsibility for services rendered to a minor, incapacitated or otherwise legally dependent patient. The guarantor may be a family member or a non-family member with legal authority to act on the patient's behalf, including the authority to consent to services. By signing this form as guarantor on behalf of a minor, incapacitated or otherwise legally dependent person, you represent to Cornerstone that you have such authority.

Please initial the following:

____I (patient/guarantor) hereby acknowledge that I have been provided with a copy of the Cornerstone Therapy Associates Treatment and Payment Policy.

For office use only:

___A copy of the Cornerstone Therapy Associates Treatment and Payment Policy was made available to the patient/guarantor and the patient/guarantor refused to initial the acknowledgement.