Mountain View REHABILITATION
MEDICAL ASSOCIATES
NONSURGICAL ORTHOPEDICS

Office and Financial Policies

Welcome to MOUNTAIN VIEW REHABILITATION MEDICAL ASSOCIATES (MVRMA). We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our *Office and Financial Policies* which we require you to read and sign prior to any treatment.

INSURANCE AND PAYMENTS

I understand that medical insurance plans and policies vary and there may be limitations and exclusions in my plan of which I or MVRMA may not be aware. I also understand that actual benefits can only be determined by my insurance company. This applies to all medical insurance plans.

I understand that my contract for health insurance is between me and my insurance company. MVRMA is not a party to that contract. I understand that it is entirely my responsibility to know the benefits and limitations of my insurance plan including effective dates of coverage, deductible, and co-pay/co-insurance due. I agree to be responsible for all charges not covered by my insurance plan. I will notify MVRMA immediately if there are any changes in my insurance coverage.

Regarding insurance plans where we are a participating provider:
All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

Payment for services:
Payment is due in full at the time of service for those without insurance coverage or with insurance plans with which we are out of network.

NO SHOW & LATE CANCELLATION

I understand that if I am late for an appointment then I may need to be rescheduled. I understand that it is my responsibility to know the date and time of my next appointment. If I miss an appointment at the scheduled time, there may be a $50 charge due prior to the next appointment. A missed appointment is defined as one in which there has been no notification of cancellation from the patient at least one full business day prior to scheduled appointment.

MEDICATIONS

I understand that MVRMA requires three (3) business days advance notice of medication requests and refills.

I have read the *Office and Financial Policy*. I understand and agree to this policy. I also acknowledge the receipt of Mountain View Rehabilitation Medical Associates *HIPAA Notice of Privacy Practices*.

Patient Name: _____

Signed:_____ Dated: _____