

Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Payment Policy

**Responsibility**- You are responsible for payment for all services rendered by RSI. We will assist in this process by submitting claims to your insurance, creating payment agreements, tracking payments, send statements, etc. as a service to you as listed in the sections below.

**Insurance (Referrals, Prior Authorizations, Co-pay, Co-insurance and Deductibles)**- RSI will submit insurance claims and follow the explanation of benefits your insurance company provides to us. However, it is your responsibility to know what services your insurance will pay for and what your co-pays, co-insurance, and deductibles are. It is your responsibility to make sure that our office receives any referrals or prior authorizations that your insurance company requires before your visit. If our office does not receive a referral, you have the choice of rescheduling your appointment or being responsible for full payment of all charges. You are responsible for any charges that your insurance company does not pay.

Please have your insurance card(s) available for the front desk at each visit. If you change insurance coverage or insurance companies, please notify us immediately. This will insure that there is time to obtain any referrals or authorizations required under your new policy. If you do not inform us of these changes prior to your next visit, your appointment may need to be re-scheduled.

Questions regarding your coverage or insurance payments must be directed to your insurance company.

**No Insurance**- You are responsible for payment for all services at the time of service. However, if the need exists, a payment agreement may be executed as a service to you. You must inform us that you need a payment plan prior to receiving services. Minimum payment is \$75.00 per month.

**Workman's Compensation Claims**- It is your responsibility to pay for all services rendered as well as ensuring that all information necessary to file your claim is provided to us prior to your first visit. This information includes the name and address of your employer, a contact person at your place of employment, when the first report of injury was filed, your claim number, the name and address of the Workers Compensation carrier, the name of your case worker (at your Workers Compensation carrier), as well as any and all other documentation needed for your claim to be paid. We will assist as possible with submission of medical information as a service to you. You are responsible for payment in full if your claim is denied. If you cannot pay this balance in full, a payment agreement plan may be executed as a service to you. You must inform us that you need a payment plan.

**Auto Insurance Claims**- It is your responsibility to submit your medical bills and related information to your insurance company. We will provide you with a copy of the services rendered and the charges for these services. We will also provide copies of medical records with a written request from you. We do not contact your Motor Vehicle insurance carrier for you and we do not file claims to your Motor Vehicle insurance carrier for you.

**Accounts Past Due Policy**- If deemed necessary for non-payment your account may be sent to a third party collection agency. Any outstanding balance over 90 days will be subject to a one-time \$20 fee & 12% annual interest.

Thank you for acknowledging your understanding of these policies by signing below:

X \_\_\_\_\_