WorkStar

Injury Recovery Center

Statement of Patient Financial Responsibility

Please Review and Initial:

_____ WorkStar appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

_____ You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

_____ I have read the above policy regarding my financial responsibility to Work Star, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Work Star, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

_____ I understand that if a: WORKCOMP claim is DENIED or CONTROVERTED, NO-FAULT claim is EXHAUSTED, or Your THIRD PARTY LIABILITY (TPL) DOES NOT include MEDICAL COVERAGE therefore, in order to continue care, incase of those circumstances or for any other reason, we require your PRIVATE INSURANCE be on tile so that you do not be " Stuck with the Bill". Furthermore, without this essential information we may be unable to continue care.

Co-Pay Policy

_____ I understand some health insurance carriers require the patient to pay co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Consent for Treatment and Authorization to Release Information

_____ I hereby authorize WorkStar, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Work Star, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Cancellation / No Show Policy

_____ I understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, [may be discharged from care. Work Star will notify you in writing, via certified mail, if you are discharged from care. I have read and understand the above information, and I agree to the terms describe.

Self-Pay

_____ IF I do not have health insurance and will be responsible for services rendered here at Work Star. I agree to pay Work Star, the full and entire amount of treatment given to me or to the above named patient at each visit.

_____ I have read the NOTICE OF PRIVACY PRACTICES for Work*Star Occupational Health Systems, Inc. I fully understand my rights and also have been informed that I may request a copy from the receptionist.

If patient is under 18, a signature is required by a patient of legal guardian.

Patient/Parent/Guarantor Signature _____ Date _____

Patient/Parent/Guarantor (Print): _____