Proactive Rehabilitation & Fitness Centers

BILLING/INSURANCE INFORMATION

Dear Patient,

We are delighted that you have chosen us as your provider. We understand that insurance benefits can be confusing, and we want to provide information to help you make informed decisions about your care. Please read carefully and initial acknowledge your understanding. If you have questions, please ask.

Insurance companies provide many different policies to meet the needs of their policyholders. In most instances, the policy holder needs to meet a set deductible before the coverage can begin. The deductible, if any, can range from several hundred to several thousand dollars.
When you schedule your appointment with us, we confirm your insurance eligibility and check your benefits. We can see if you have met your deductible and what is the coinsurance amount on your policy. Based on the information we obtain we can foresee the portion of the bill that you will owe to us. As such, we respectfully ask for **a copayment** to be made at the time of your visit. This copayment will NOT cover the full cost of your visit. The copayment will only help with the portion of the costs we are anticipating you will owe for services. Refunds, if any, will be issued if necessary. Initials _____

Many insurance companies impose a **visit limit** for therapies. Often there is a different visit limit for occupational therapy then the visit limit for physical therapy. Your benefit might have a visit limit associated with your treatment at Proactive. Please contact your insurance to be certain that you are fully aware of all the benefits, including any potential visits limit. If the allowed limit for therapy is exceeded, insurance can and will deny the coverage. Initials _____

As a courtesy, we bill any insurance that you provide. We allow 45 days for insurance to receive the claim and determine if they will pay for the services. **After we receive a determination and payment from your insurer, we will bill you for the balance**, if any. Initials _____

Once again, we encourage you to contact your insurance provider directly to ensure that you understand your benefits. You can generally find their contact information on the back of your insurance card.

Sincerely,
Proactive Billing Department

Pinedale Office
317 N Faler Avenue
Pinedale, WY 82941
P: (307) 367-6236
F: (307) 367-3332

Mailing Address
PO Box 1037
Pinedale, WY 82941

Marbleton Office
307 Main Street
Marbleton, WY 83113
P: (307) 276-3050
F: (307) 276-3062

www.proactiverehabilitation.com

DEFINITIONS

- **Allowed Amount:** The maximum amount a plan will pay for a covered health care service. May also be called “eligible expense,” “payment allowance,” or “negotiated rate.” If your provider charges more than the plan’s allowed amount, you may have to pay the difference. (See Balance Billing)
- **Annual limit**: A cap on the benefits your insurance company will pay in a year while you are enrolled in a particular health insurance plan. These caps are sometimes placed on services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.
- **Balance Billing**: When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30.
- **Claim:** A request for payment that you or your health care provider submits to your health insurer when you get items or services you think are covered.
- **Coinsurance**: The percentage of costs of a covered health care service you pay (20%, for example) after you have paid your deductible.
- **Deductible**: The amount you pay for covered health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself.
- **High Deductible Health Plan (HDHP):** A plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs yourself before the insurance company starts to pay its share (your deductible).
- **In-network Coinsurance:** The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network coinsurance usually costs you less than out-of-network coinsurance.
- **In-network Copayment**: A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.
- **Network**: The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.
- **Out-of-Network Coinsurance:** The percentage (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.
- **Out-of-Network Copayment:** A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.
- **Out-of-Pocket Costs**: Your expenses for medical care that are not reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that are not covered.
- **Out-of-pocket maximum/limit:** The most you must pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits. The out-of-pocket limit does not include your monthly premiums. It also does not include anything you spend for services your plan does not cover.
- **Preauthorization**: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization is not a promise your health insurance or plan will cover the cost.

Definitions obtained from: https://www.healthcare.gov/glossary

DISCLAIMERS AND POLICIES

Insurance Disclaimer: A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member’s contract at time of service.

Patient Agreement: I understand that my health insurance company may deny payment for services. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

A full version of our financial policy is provided to you in the office policies that you must agree with to receive treatment.