Robert Rundorff, MD

Board Certified

Physical Medicine and Rehabilitation

Financial Policy

Your clear understanding of our Financial Policy is important to your care. A health insurance policy is a contract between you and your insurance company. Your insurance company determines what amount, if any, you owe. If there is a balance due on your account, you will receive a monthly statement, of which a payment is due within 30 days of receipt. If you cannot meet this requirement, please contact our office for payment arrangements. If your insurance requires a referral, *it is your responsibility to make sure we have the referral from your primary care physician*.

Co-Pays

Your insurance carrier requires that we collect co-payments. Co-payments are due at the time of service. If you are unsure of your co-pay amount, please contact your insurance provider.

Self Pay Patients

If you do not have insurance, we can provide you with a 45% discount for payment on the day of service. If you cannot pay at the time of service, please contact the office to set-up a payment arrangement prior to your first appointment.

Workers Compensation and Personal Injury

Worker's Compensation and motor vehicle accident patients must provide the following information:

- Insurance company name, address, phone number, date of injury, and claim number.
- Attorney's name and phone number if an attorney is involved.
- Major Medical Insurance information even though it will be billed to your liability insurance.

We require that you allow us to bill your health insurance upon denial of any workers compensation or personal injury claim. If your claim is in litigation we will stay in communication with your attorney regarding the status of your case; but payment of the bill remains the patient's responsibility.

Forms and Records Request

Patients may request forms be filled out for credit card and bank deferments, insurance purposes, applications for disability, Medicaid requests, and legal matters. There is a $5.00 fee per form. The patient part of the forms must be filled out in their entirety. The office will take 3 to 4 business days to get the forms done, at which time the office will fax or mail the forms to the required organization. It is the patient's responsibility to provide the office with the fax number or mailing address. There will be a $25.00 fee for most records requests; records will be ready in 5 business days.

Patient Attendance and Scheduling Policies

In accordance with our mission, we have adopted the following attendance/scheduling policies to enable all of our patients an equal opportunity for available appointment times while seeking treatment here.

1. Patients are required to give a 24 hour notice prior to any canceled or rescheduled appointments for doctor's visits and balance assessment appointments. Patients are allowed a total of three rescheduled appointments.
2. For VNG, EMG, or NCV testing appointments, patients are required to give a 48 hour notice prior to any canceled or rescheduled appointment. If the patient does not give the required notice, and they wish to reschedule, they will be rescheduled at the office's convenience.
3. If a patient NO-SHOWS for an appointment twice, they may reschedule to the next available appointment. If a patient NO-SHOWS three or more times, they may be discharged from the practice and their records will be forwarded to the doctor of their choice.
4. If a patient is more than 15 minutes late for their appointment or the patient's paperwork is not completed at the time of their appointment, the appointment may be rescheduled.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY.

Patient/Guardian Signature:_____ Date: _____

16 Rose Street ▪ Johnstown, PA 15905 ▪ Phone: 814-539-0257 ▪ Fax: 814-536-0963

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Consent for Treatment, Records Release, and Assignment of Benefits Form

Before you begin treatment, the law requires that we explain your rights and responsibilities while a patient at our clinic. If you have complaints or concerns about your care, please discuss it first with you the doctor or your primary care provider. If your concern remains unresolved, you may file a complaint with the Privacy Officer/Office Manager. If still not resolved you may file a report to The Department of Health and Human Services.

Consent for treatment: By signing this form, I consent to and authorize my health care provider to examine and treat me. I understand that my provider is available to explain the purpose of the procedures and treatment, and that I have the right to refuse the recommended treatment. No guarantee or assurance has been made to the results that may be obtained.

Agree to the terms of Financial Policy: Which I have received a copy of.

Release of Medical Records: I understand that it is important that my providers have access to medical records which will help them to safely treat me and manage my care. I also understand that they will release medical information to contracted providers and medical transcribers for purposes of medical care and business operations. Evaluations and test results generated at this office will be automatically mailed to your referring physician. In many instances a third party payer or attorney will pay a portion or all of my medical bills. In order for a third party payer to pay the bills related to my visits at this office, they may require chart notes be forwarded to them. I authorize Robert Rundorff, MD to release any information to determine the payments related to the medical treatment I receive.

Insurance/Medicare/Medicaid Assignment of Medical Benefits: I would like a "third party payer" to pay the bills for my services at Robert Rundorff, MD, to the extent the Payer is required to do so under my policy of insurance or the law. Therefore, I request that payment of my bills by the "third party payer" be made to Robert Rundorff, MD on my behalf for any services furnished to me by or in Robert Rundorff, MD. I assign the benefits payable for services to the provider or organization furnishing the services. In addition, I agree to pay for all charges not covered by a third party payer.

Consent to the use and disclosure of health information for treatment, payment, or operations: I acknowledge that I have been made aware of the privacy practices of Robert Rundorff, MD, if I would like a copy of this notice I may ask for one, the notice is also posted in the reception area. I also understand that I have the right to revoke this consent, in writing, at any time except where this office has already made disclosures in reliance on this consent. Robert Rundorff, MD is not required to agree to all the restrictions requested. I understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. Robert Rundorff, MD reserves the right to change their notice and practices, in accordance with Section 164.520 of the Code of Federal Regulations. I understand that as part of this organizations treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosures for these permitted uses, including via fax.

By signing below I agree to the above statements.

Signature of Patient/Other _____ Date: _____

Printed Name: _____ Patient Date of Birth: _____

If other, Relationship to Patient: _____