Health Insurance Reimbursement Policy

Kathy Scarpello, LMP

I understand that I am responsible for all fees incurred as a result of my treatments with you.

I will keep a current physician's referral on file with you, regardless of whether my health policy requires it, and assume responsibility for making sure it is up to date. I understand that a physician's referral does not necessarily mean that the insurance company will reimburse you for your services.

Health insurance will pay for bodywork when it is "Medically Necessary", defined as restoring lost function due to illness or injury. They can and do deny payment when, in their view, the criteria are not met.

Insurance companies reimburse for **one hour** of treatment per visit. I understand that any extra time spent on a treatment is my personal financial responsibility and agree to pay the difference between the allowed rate and your regular fee, payable at the time of service.

I understand that I am personally financially responsible for all co-pays and deductible payments at the time of service. If my claims are denied, I will reimburse you within 30 days of denial.

I take responsibility for dealing with my insurance company if I disagree with their reasons for denied payment, and will pay you in a timely manner out of my own pocket until such time as the insurance company can be coerced into payment.

I have read and agree with all of the statements above.

Signature _____

Date_____

Information Disclosure Consent Form

Kathy Scarpello, LMP

In this document, “I” and “my” refer to the patient, and “Practitioner” refers to Kathy Scarpello.

I consent to the use or disclosure of my protected health information by Practitioner for the purpose of analyzing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Practitioner. I understand that analysis or treatment of me by Practitioner may be conditioned upon my consent as evidenced by my signature below.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Practitioner describing the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Practitioner.

Practitioner reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Practitioner and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Printed Name of Patient

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Signature of Patient or Personal Representative _____ Date of Signing _____

Description of Personal Representative’s Authority _____