LAFAYETTE Rehabilitation Services

A UNITY HEALTHCARE PARTNER

BILLING POLICIES

Please contact your insurance company for your specific benefit information. Charges for outpatient Physical / Occupational Therapy are usually covered under your health insurance. Lafayette Rehabilitation Services (LRS) will bill your insurance company for you as a complimentary service. We do ask that you pay your co-pay at the time of service.

All charges incurred at Lafayette Rehabilitation Services are the responsibility of the patient. Any portion of your bill that is not paid by your insurance company, including non-covered services/supplies, and coinsurance will be billed to you and is due upon receipt. All returned non-sufficient funds checks will be charged $20.00.

Accounts that have received at least two patient statements with no payments being received will be considered past due. Past due accounts will be transferred to a collection agency. Any accounts transferred to the agency will be assessed all reasonable costs or collection agency fees, attorney's fees and court costs. These additional costs will be added to the original outstanding balance due.

If necessary our business office will assist you in setting up a payment plan for the balance on your account not paid by insurance.

Appointments are in high demand. If you cannot make your appointment, please cancel it as soon as possible so we can help someone else. If you fail to attend multiple appointments without calling or cancel multiple times, you may not be allowed to reschedule.

There will be a $30.00 charge for any no-show or for a cancellation with less than 24 hours notice prior to the scheduled appointment time. We reserve the right to refuse to allow you to reschedule after multiple missed appointments.

Payment Agreement: I hereby authorize Lafayette Rehabilitation Services to treat myself or my minor child/dependent and to submit medical claims to my insurance carrier or its intermediaries for all covered services rendered to me by Lafayette Rehabilitation Services, and direct insurance carrier or its intermediaries to issue payment check(s) directly to Lafayette Rehabilitation Services. If for any reason my claim is denied and payment for therapy is stopped, I agree to pay in full any charges that are outstanding.

Signature:_____ Date: _____

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