**PAYMENT POLICIES**

**WORKOUTS MENU**

Three hour workouts with or without FES RT300/600 $250.00

One hour Workouts - $95.00

FES RT600 Stand-alone Sessions - $95.00

FES RT300 Stand-alone Sessions $50.00

\*FES pads are an additional charge\*

For clients who will be coming on a weekly basis, the initial two hour trainer evaluation is free of charge.

We will need to discuss our fees prior to the beginning of your treatment. Payment of fees for services rendered is expected at the time services are provided. Payments must be made by **check or credit card only**. Returned checks are subject to a $35 fee.

We file insurance as a courtesy to our patients. However, we do require co-payments to be paid at the time of the service. All clients will be billed at the end of the month. Sessions and hours will be billed based on actual attendance. Clients must inform us prior to the first of the month if a known appointment time cannot be kept for scheduling purposes.

Every client will be required to provide a valid credit card and keep it updated to pay any invoice that is past 30 days due, plus a $50 late fee. **This credit card will ONLY be billed in these case, and will not be taken for regular, on-time payments.**

**CANCELATIONS:** Since our profession is based on an appointment schedule, our policy is to charge for missed appointments, unless your appointment is cancelled within 48 hours in advance. Any session cancelled with less than 48 hours’ notice (including weekends for Monday appointments) WILL BE BILLED at $95.00 per hour, with the exception of medical emergencies. Cancelations MUST be made to the office phone number (813-977-7999) or by email at diosa@stayinstep.org. If no one answers, you must leave a message. E-mails, text messages and calls to trainers’ cell phones are not acceptable and are not valid for cancellation purposes. In case of a true emergency, Patricia Diosa can be called on her cell phone at 813-966-2259.

Invoices are prepared on the last day of the month. Payment is due by the 10th of the month following the sessions. Any payment received after the 10th is subject to late fee of $50.00. If payment is not received by the 15th, client will be removed from the schedule until full amount of invoice is received. If payment is not received within 30 days, the credit card provided WILL be charged $50 late fee.

Client Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_

**Insurance Assignment and Release**

I, the undersigned, have insurance coverage and assign directly to *Stay in Step, Spinal Cord Injury Recovery Center*., all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of his signature on all my insurance submissions. I am responsible for any fees that *Stay in Step, Spinal Cord Injury Recovery Center*., incurs for the full collections of payments.

Signature of Patient/ Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medicare Authorization**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to *Stay in Step, Spinal Cord Injury Recovery Center*., for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and no covered services. Coinsurance and deductible are based on the charge determination of the Medicare carrier.

Signature of Patient/ Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date