TRIAD INTEGRATED MASSAGE THERAPY

NYSHIP PATIENT PAYMENT AGREEMENT

Date : _____

Patient Name: _____

Name of Person Financially Responsible: _____

Thank you for choosing **TRIAD INTEGRATED MASSAGE THERAPY**. We are dedicated to providing you the best possible treatment and care. As part of your care we offer our NYSHIP patients the following payment agreement for their out of network treatment.

A. As a courtesy to you, we will file all requisite insurance claim documentation with NYSHIP. However, you are responsible to know the limits of your insurance and the extent of your benefits.
B. Services will be charged one hundred dollars ($100.00) per service unit equal to fifteen (15) minutes of treatment service time. We cannot guarantee what your insurance will pay.
C. You are responsible at the time of service for the payment of any known deductible, co insurance, or co-payment.
D. You are responsible for the remainder of the full payment for all services rendered. It is the policy of **TRIAD INTEGRATED MASSAGE THERAPY** to require full payment at the time each individual service is rendered.
E. Notwithstanding this policy, and as a courtesy to NYSHIP members, **TRIAD INTEGRATED MASSAGE THERAPY** will not require payment at the time of individual service but will allow for payment within sixty (60) days of each individual treatment session. The sixty (60) day payment window will allow appropriate time for you to receive payment for your out of network benefit from NYSHIP.

Patient Name:_____

Signature of Patient or Responsible Party:_____

Date: _____

Name of Person Financially Responsible: _____
authorizes Triad Integrated Massage Therapy to keep my signature on file and to charge my Visa / Mastercard for all charges incurred and outstanding for sixty (60) days, whether or not payment has been received from my insurance company as reimbursement for out of network charges provided to _____.
This authorization shall be valid for all visits and treatment by Triad Integrated Massage Therapy commencing on _____ until treatment services are terminated.

Patient Name: _____

Cardholder Name: _____

Cardholder Address, City, State, Zip
_____
Credit Card Type:
Mastercard _____
Visa _____

Account Number: _____

Expiration Date: _____ CVV#_____

Date _____

Cardholder signature Name (as it appears on card): _____

TRIAD INTEGRATED MASSAGE THERAPY

OUT OF NETWORK DISCLOSURE AND PAYMENT AGREEMENT

We understand that healthcare costs can be worrisome. We are an out of network healthcare provider with NYSHIP. In many instances, your health plan may not fully pay our charges for medical services. As a result, we have an obligation to bill you for the coinsurances, deductible and cost share amounts for non-covered services. You, the patient (or patient's guardian if a minor) agree that you will be responsible for these potential fees.

Should your insurer remit reimbursement to you directly, you agree to forward these reimbursements to **TRIAD INTEGRATED MASSAGE THERAPY** in a timely manner. Insurance checks must be endorsed to **TRIAD INTEGRATED MASSAGE THERAPY** (signed on the back)
The EOB (explanation of benefits) must accompany the check.
If two providers are listed on the same check, it is your obligation to provide payment to each provider separately, providing each with a copy of the EOB.
Should payment for said services not be forthcoming, the matter may be referred to an attorney for collection. If the matter is sent to an attorney, in addition to the full balance due, the patient will also be responsible for legal fees and court costs in connection with the collection of the said amount.

We recognize that not all of our patients will be able to afford their patient cost share amount. We have therefore created a Financial Hardship Policy. This policy legally permits us to reduce and, in some cases, waive the patient cost share amount. If you believe you might qualify for financial assistance, please ask our staff for a copy of the Financial Hardship Policy.

AGREED TO BY:_____
(PRINT NAME)

AGREED TO BY:_____
(SIGN NAME)

AGREED TO BY:_____
(MINOR LEGAL GUARDIAN SIGNATURE)

DATE:_____

TRIAD
INTEGRATED
MASSAGE THERAPY

Triad Integrated Massage Therapy

17 Technology Drive

East Setauket, NY 11733

I, _____ understand that a payment for services rendered may be delivered to my residence. I understand that I will sign the insurance check, endorse it over to Julio Genao and will bring the check as well as the original EOB (Explanation of Benefits) to 17 Technology Drive East Setauket, NY 11733.

_____

Patient Name

_____

Date

UnitedHealthcare®

Designation of Authorized Representative

Member Name (*please print*)	Date of Birth	Member ID Number	
Member's Street Address	City	State	Zip
Designated Representative's Address	City	State	Zip
17 Technology Drive	East Setauket	NY	11733
Provider of Service			
Julio Genao,LMT			
Date(s) of Service or Proposed Service			
ANY AND ALL DATES OF SERVICE AND CPT CODES BILLED BY JULIO GENAO, LMT			

I, _____, am appointing
Print the name of the member who is receiving the service or supply

DEBRA YELLER FOR JULIO GENAO, LMT
Print the name of the person/organization who is being authorized to act on the member's behalf

To act on my behalf as my authorized representative for (*check all that apply*)

X a complaint X an appeal X documents from UnitedHealthcare regarding the above-noted service or proposed service.

I understand and agree that:

- This authorization is voluntary;
- my health information may be disclosed to my authorized representative and may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulation;
- this authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying UnitedHealthcare in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Signature of Member or Approved Party	Date
If person signing this authorization is not the member, describe relationship to the Member (i.e. Parent, Legal Representative)	

Legal Representatives signing this authorization on behalf of a member must furnish a copy of a health care power of attorney, or other relevant document that grants the applicable legal authority