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.

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:_____