Arete Rehab, PLLC Payment & Medical Insurance Policy & Procedures

Dear Patient,
This letter is to inform you of our billing procedures. We ask you to please read the following information carefully and sign below.

Patients with Private Insurance: We do not participate with any insurance. We are " Out of Network."

Payment is due at the time of service.

As a courtesy, Arete Rehab, PLLC will assist you in attaining payment from your insurance carrier by providing a Super Bill. **Remember**, your Insurance coverage is a contract between you and your insurance company.

Medicare Patients: Arete Rehab, PLLC does participate with Medicare. **However**, **We DO NOT participate with Medicare Advantage Plans.** We are happy to bill Medicare on your behalf. If Medicare denies the claim for what ever reason, **YOU WILL BE RESPONSIBLE FOR THE FULL AMOUNT. All claims not paid within 60 days will automatically be your responsibility.**

Any and all controversies, disagreements, disputes, claims or arguments arising out of or relating to these policies and procedures, or any breach thereof or relationship of the parties shall be settled by arbitration in Yavapai County of Arizona in accordance with the commercial Rules of the American Association then in effect, judgement upon the award may be entered in any court having jurisdiction thereof. The legal fees and cost of the proceeding shall be borne by the non-prevailing party and set forth in the award.

I have read the above information concerning payment and medical insurance policy and procedures of Arete Rehab, PLLC. I have asked any questions that I may have and I understand and agree to comply with the above policies and procedures.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO PAY THE ENTIRE BILL REGARDLESS OF THE DISPOSITION OF MY CLAIM. SHOULD COLLECTION PROCEDURES BE REQUIRED TO COLLECT ANY BALANCE OWED TO ARETE REHAB, PLLC FOR SERVICES RENDERED, I WILL BE RESPONSIBLE FOR ALL COURT AND LEGAL COSTS. I further authorize Arete Rehab, PLLC to release any and all medical records to my insurance carrier and attorney as required for payment of the charges of Arete Rehab, PLLC.

Patient Name:_____ Patient Signature:_____

Date:_____ Witness (Arete Rehab Staff)_____

EMERGENCY CONTACT INFORMATION

Name of Contact:_____ Relationship of Contact:_____

Phone Number:_____

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