**FINANCIAL RESPONSIBILITY POLICY / INSURANCE AUTHORIZATION**
**MICHIGAN ABILITIES CENTER**
**PHYSICAL MEDICINE AND REHABILITATION, PLLC**
**Steven R. Hinderer, MD**

**CLIENT NAME: _____**
**Last First Middle Initial**
**DOB____/____/____**

Thank you for choosing the Michigan Abilities Center Physical Medicine and Rehabilitation (MAC PM&R) as your healthcare provider. This document is a summary of our financial policies, and explanation of your responsibilities, and authorizations to bill your insurance on your behalf for services provided to you.

You may be responsible for copayments, deductibles and services provided which may not be considered a benefit under your policy. All co-pays, deductibles, and unpaid balances are due at time of visit, or by date of statement. Your insurance may deny claims for a variety of reasons:

1. The services provided may not be a benefit for your health insurance policy or may not be covered when provided by our office (e.g., mental health services, laboratory, etc).

2. You may have exhausted your benefit for the services provided.

3. MEDICAL NECESSITY or MEDICALLY NECESSARY generally means a determination based upon criteria and guidelines developed by your insurance carrier in consideration of generally accepted standards and practices. The services must meet all of the following criteria:

   a. It is generally accepted as necessary and appropriate for the patient's condition, given the symptoms, and is consistent with the diagnosis; and

   b. It is essential or relevant to the evaluation or treatment of the disease, injury, condition or illness and is not mainly for the convenience of the member or physician; and

   c. It is reasonably expected to improve the patient's condition or level of functioning or, in the case of diagnostic testing, results are used in the diagnosis and/or managements of the patient's care.

**Collections / Fees**

1. There may be a $75.00 charge for office appointments that are "No Show, No Call". This also applies to any cancellations less than 24 hours prior to my appointment. If you arrive more than 15 minutes late for your appointment you may be charged a $25.00 fee and asked to reschedule your appointment.

2. There is a $25.00 fee for returned checks. A $15.00 billing fee may be added to my balance for all unpaid balances and co-pays due at time of visit.

3. In the event that my unpaid balance needs to be sent to collections, I will be responsible for all collection fees, attorney fees, and any other fees incurred in the collections process.

**Signature:_____ Date:_____**
**Signature of Client / Responsible Party (**guardian or parent if under 18 years old)