



360° Balance

Specializing in dizziness, balance and hearing disorders.

STATEMENT OF FINANCIAL RESPONSIBILITY

Patient Name: _____ **Date:** _____ **Acct #:** _____

At 360 Balance, our mission is to value every individual and meet the healthcare needs of patients and their families that suffer from dizziness, balance and/or hearing disorders. The service you have elected to participate in implies a financial responsibility on your part. You are responsible for payment of any co-payment at the time of service and on receipt of a bill for any deductible/coinsurance as determined by your contract with your insurance carrier. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. If collection for this invoice is placed in the hands of an attorney, attorney fees equal to 30% of the total invoice price shall be due and owing. If any legal action is required, it is agreed that the venue for such shall be in Travis County, Texas.

I have read the above information regarding my financial responsibility to 360 Balance for providing services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to 360 Balance. I agree to pay 360 Balance the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier.

Signature: _____ (relationship to patient: self - guardian - other: _____) **Date:** _____

Billing Disclosures, Notice of Privacy Practices and No Show Policy:

I hereby authorize 360 Balance to furnish information to insurance carriers and doctors concerning my illness and treatments, by fax or mail.

Signature: _____ (relationship to patient: self - guardian - other: _____) **Date:** _____

I hereby authorize 360 Balance to disclose my health information that is directly related to my current treatment at 360 Balance to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received. Such persons involved in your care may include: spouse, children, blood relatives, roommates, boyfriends/girlfriends, domestic partners, neighbors and colleagues.

NAME: _____ **RELATIONSHIP:** _____

I acknowledge that the Notice of Privacy Practices is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.

There is a \$20 no-show/late-cancellation fee. All appointments must be cancelled by 5 p.m. of the previous day (or by 5 p.m. on Friday for a Monday appointment), to avoid charges for a no-show or late-cancellation. After-hour messages regarding cancellations may be left at 512-345-4664. Insurance will not cover charges for no-show/late-cancellation or eligibility fees. I acknowledge that I have read and understand the No Show Policy.

Signature: _____ (relationship to patient: self - guardian - other: _____) **Date:** _____

Computerized Dynamic Posturography:

Your insurance carrier does not pay for all your health care costs. Your carrier only pays for the covered items and services when certain rules are met. The fact that your carrier does not pay for a particular item or service does not mean that you should not receive it. There is good reason your healthcare provider recommended it. In your case, your carrier will not pay for the following: **Computerized Dynamic Posturography.**

Because: The diagnostic test may not be a benefit from your carrier, therefore, your carrier may determine it is not medically necessary. Please keep in mind that as a defined benefit plan, your carrier's denial of a procedure as "not medically necessary" is not a statement about the quality or appropriateness of the care and service. We must emphasize that, in our professional judgment, these services are necessary in order to render quality medical care.



PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE:

- YES ~ I want to receive these items or services.** The fee for this service will be \$30.00.
- NO ~ I have decided not to receive these items or services.**

Signature: _____ (relationship to patient: self - guardian - other: _____) **Date:** _____