# PHYSICIAN/SUPPLIER NOTICE TO BENEFICIARY

## CANCELLATION POLICY

Your physician has requested you undergo testing to diagnose and properly treat your condition. These procedures require the use of sophisticated equipment and highly-trained professionals for their completion. Several tests are typically scheduled together for your convenience and may require 2–3 hours. Instructions will be given to you in preparation for these studies. We will attempt to contact you to remind you of this appointment.

If you are unable to make this appointment, we ask that you notify our office as soon as possible. This time is extremely valuable to us and other patients who require similar evaluation and treatment. It is our policy to charge a cancellation fee of **$50.00** if you do not contact this office at **941.749.5222** to cancel or reschedule this appointment at least **24 HOURS** prior to your appointment.

Thank you in advance for your cooperation. We look forward to serving you!

## BENEFICIARY'S ACKNOWLEDGEMENT AND AGREEMENT TO PAY

I understand that the cancellation fee noted above is NOT covered by my Medicare and/or private insurance. I further agree to be personally responsible for payment if I do not provide proper notification prior to cancellation.

________________________________________ _________________________

Beneficiary's Signature Date

________________________________________

Print Name

# PHYSICIAN/SUPPLIER NOTICE TO BENEFICIARY

At present, most insurance companies will deny payment for Computerized Dynamic Posturography testing. Although we believe that this tool is extremely useful in the diagnoses and management of your balance disorder, the acceptance and implementation of new medical technology by the medical community commonly outpaces the ability of third-party payers to assign codes for them. These procedures are currently being used at many sites throughout the United States and Europe, and were registered with the Food & Drug Administration of the Department of Health and Human Services in accordance with the Medical Device Amendments in April of 1985. Efforts are currently under way to include this testing as a covered service within private insurance guidelines, but as of yet have not been successful.

## BENEFICIARY'S ACKNOWLEDGEMENT AND AGREEMENT TO PAY

CPT 92548: If you have questions regarding the insurance coverage of Computer Dynamic Posturography, please contact your insurance provider directly referencing CPT code 92548 for additional information regarding or understanding any potential out of pocket expense.

I have been notified by my physician/supplier that he or she believes that, in my case, private insurance is likely to deny payment for the services identified above. I agree to be personally and fully responsible for payment at time of service.

______________________________ ______________________

Beneficiary's Signature Date

______________________________

Print Name

# PRIVACY AUTHORIZATION AND VERIFICATION

**Please answer the following questions to help us protect your privacy:**

Is it okay to leave a detailed message on your answering machine? ☐ YES ☐ NO

Is it okay to release information to anyone other than you? ☐ YES ☐ NO

If answer is YES, please list each person (REMINDER: WE WILL NOT RELEASE INFORMATION TO ANYONE NOT LISTED):

Name_______________________________ Relationship_______________________________________

Name_______________________________ Relationship_______________________________________

Name_______________________________ Relationship_______________________________________

This is to verify that I have read and understand the above information. By signing this statement, I am giving The Practice and its staff consent to release my personal information as described above.

Signature_____________________________________________ Date___________________________

Print Name___________________________________________

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**I ALSO ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE PRACTICE PRIVACY POLICY BROCHURE AND HAVE BEEN GIVEN AN OPPORTUNITY TO READ IT AND ASK QUESTIONS**.

Signature_____________________________________________ Date___________________________