Patient Information/Responsibilities
Phase II Cardiac Rehab Program

Scheduling

We will work with you and your physician to optimize the outcome. It is important that you attend all of your scheduled therapy sessions.

- Please give at least 24 hours notice if you must cancel.
- It is your responsibility to call and cancel your appointment if you are unable to keep it.
- It is your responsibility to arrive to your appointments on time and dress appropriately for your appointments.
- **If you miss more than three (3) appointments without notifying us to cancel, you will be discharged and your physician with be notified.**

Insurance

Patients are responsible for knowing their benefits and assuring that authorization, if required, is obtained. Contact your insurance company directly for an explanation of your benefits
If your doctor requests services for Cardiac Rehabilitation, these services may be payable under your insurance contract. Your rehabilitation must be medically necessary and you must be making documented progress. Your insurance company may request medical records prior to payment.

Some insurance companies restrict payment for certain diagnoses. You may wish to talk with the cardiac rehab staff regarding your particular diagnosis and check with your insurance company for any special restrictions.

Determination of insurance payment can only be made after your insurance company has reviewed our billing and documentation. You will be responsible for paying any amount due that your insurance does not cover.

You must notify us immediately to discuss any changes in your insurance while you are undergoing therapy.

I confirm that the registration information given is correct. I hereby give authorization to Sparrow Health System to release any medical information requested by the insurance provider responsible for payment. I understand I am responsible and agree to pay for services rendered if not covered by my insurance provider.

I HAVE READ AND UNDERSTAND THE ABOVE AND ACCEPT PERSONAL RESPONSIBILITY FOR PAYMENT OF NON-COVERED SERVICES.

Patient Name: _____ Date of Birth: _____

Witness: _____ Date: _____