Therapy Innovations

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PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for allowing Therapy Innovations to assist you with your therapy needs. Our primary responsibility is to help our patients improve their quality of life by achieving their goals. In addition, we strive to maintain a good therapist-patient relationship. Letting you know in advance of our policies allows for a good flow of communication and enables us to achieve our goal. Your clear understanding of the financial policy agreement is important to maintain our good relationship.

We must emphasize that as a therapy provider, our relationship is with you, not your insurance company. While filing the insurance claim is a courtesy that we extend to our patients, a charges not covered by your insurance company are strictly your responsibility.

- According to your insurance plan, you are responsible for any and all co-pays, deductibles, and co-insurances.
- It is your responsibility to understand your benefit plan.
- Insurance plans vary greatly, and we can not predict or guarantee what part of our services will or will not be covered.
- It is your responsibility to keep us updated with your correct insurance information.

BILLING

You, as the parent and/or guardian, are the "responsible party" and authorize the release of information pertaining to the patient's diagnosis and course of treatment to Therapy Innovations, Inc. by the patient's physician and any other therapy service providers involved in the patient's care. You also authorizes the release of information to the patient's physician and any other agencies related to reimbursement issues.

- You understand that the verification of benefits is not a guarantee of payment and that they are responsible for all charges not paid by the insurance company.
- We accept cash, check, or credit card (Visa or Mastercard).
- All copayments, coinsurances, and out of pocket payments for the rendered therapy service will be due at time of service. The exception is if your child's therapy takes place outside the office, in which payment will be due within 24-hrs of service.
- If we do not participate in your insurance plan, payment in full is due at time of service. You may be eligible for our "self-pay" rate; please speak to our billing department if you have not already filled out this form.
- If previous arrangements have not been made with our billing department, any account balance outstanding greater than 30-days will be charge a $20.00 re-bill fee. Any balance over 90-dayswill be forwarded to a collection agency.
- A $20.00 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
- Broke appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. We reserve the right to charge a fee for canceled or missed appointments. A $25.00 fee will be charged for a second missed appointment. After a third missed appointment, you will be charged and your child taken off of the schedule. PLEASE REFER TO OUR CANCELLATION POLICY.

Client's Name: ____________________________

Parent/Guardian's Name _______________________________________

Responsible Party's Name: _____________________________________

Primary Insurance/ID Number: ____

Deductible: ______________________________________ Copay/Coinsurance: _________________

Secondary Insurance/ID Number: ____

Deductible: ______________________________________ Copay/Coinsurance: _________________

By signing below, you are stating you have read the "PATIENT FINANCIAL RESPONSIBILITY AGREEMENT" and agree to the terms.

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Parent/Guardian's Signature Date