Pediatric Therapy Links, LLC

Phone: (772) 291-2179 · Fax: (772)-600-8274 · info@pediatrictherapylinks.com

Patient Name: ____ **Patient DOB:** _______________

Financial Policy

Thank you for choosing Pediatric Therapy Links, LLC to provide you with your child's speech language therapy and/ or occupational therapy services. We are pleased to participate in the care of your child and look forward to providing you with excellent therapy services. As a part of this relationship, we wish to establish certain expectations of your financial responsibilities outlined in this policy.

Payment Responsibility

I understand as a recipient of medical care that I am responsible for all charges regardless of reimbursement. I understand it is my responsibility to be aware of the requirements and limitations of my own insurance plan benefits. I understand there is a fee charged for all visits, evaluations, therapy sessions, and medical reports. Co-pays and/or co-insurance are due at the time of the therapy session. I agree to provide Pediatric Therapy Links, LLC with complete and accurate information required to bill my child's insurance plan. These documents might include a driver's license, insurance card, and referral or authorization prior to the scheduled visit. **I understand that if the services are not paid by insurance it is my responsibility as the parent to pay for any services not covered by the insurance plan for my child. I agree to promptly pay Pediatric Therapy Links, LLC, within 7 days of being notified, the remaining balance for sessions should my or my child's insurance company deny or not cover the claims submitted for my child's therapy evaluations or therapy sessions.** During the course of therapy, I agree to promptly inform Pediatric Therapy Links, LLC if my child's insurance becomes inactive or discontinued for any reason.

Insurance

Pediatric Therapy Links, LLC will confirm your child's benefits with your health insurance plan; however, it is the patient, parent, or legal guardian of the patient's responsibility to verify coverage for the therapy services. Insurance verification is not a guarantee of payment and we encourage you to contact your insurance company to better understand your benefit for therapy services. Insurance does not pay for all of your healthcare costs and some services are considered "non-covered benefits" under your health insurance plan meaning they will not cover these services. If therapy services are determined to be "non-covered benefits" following submission of claims, ***it is the parent's responsibility to cover any non-covered balances from your child's insurance for all therapy claims***. Should you choose to have your child receive therapy services that are not covered, you will be personally responsible for the payment of such services. Once a determination has been made that the therapy services recommended are "non-covered benefits" under you plan, you may elect to continue therapy through our self-pay plan.

Missed Appointment Policy

I understand the outcome of treatment depends highly on keeping scheduled appointments that are reserved. Pediatric Therapy Links, LLC reserves the right to charge $30 for missed appointments or cancellations without a 24-hour advanced notice. If three scheduled appointments are missed, future appointments may be discontinued.

 Parent/ Guardian Initials: ________

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Returned Checks
There is a $25 charge for any returned check in addition to the original amount of the check. This must be paid by cash or cashier's check prior to the next visit.

Deliquent Accounts
If your account becomes past due with nonpayment over 30 days, we will take the necessary steps to collect this debt. You will receive a letter stating you have 10 business days to pay your account in full. Please note that if your balance remains unpaid, we will refer your account to a collection agency. If your account is referred to a collection agency, you agree to reimburse Pediatric Therapy Links, LLC any fees incurred with the collection agency including reasonable attorney's fees if needed with our collection efforts.

Statement of Confidentiality
I authorize the release of necessary medical information to Pediatric Therapy Links, LLC for the purpose of processing insurance claims. I also give Pediatric Therapy Links, LLC consent to provide any requested documents contained in my child's file to other healthcare providers involved in the treatment of my child.

Acknowledgement
I understand that as a part of my care, Pediatric Therapy Links, LLC will originate and maintain paper and/or electronic records describing my child's health history, symptoms, evaluation, testing results, diagnosis, treatment, and any plans for future care or treatment.

By signing this document, I also acknowledge that I have received and understand a copy of Pediatric Therapy Links, LLC's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPPA) to ensure that I have been made aware of my privacy rights and privileges.

I have read the updated financial policy and agree to all of its terms. All questions have been answered prior to my signing this policy.

______________________________________ ___________________
Signature Date

_____________________________________ ______________ _____________________
Print Name SSN Relationship to Patient