INSURANCE AND PAYMENT AGREEMENTAND INFORMATION:

If your insurance company covers Occupational or Speech Therapy, Pediatric Sensory Therapy can process the paperwork and bill your insurance company. It is important for you to understand insurance contracts are between you and your insurance company, and you are responsible for any amount not paid by your insurance company. In accepting your insurance company, this office is extending a credit to you. Those patients who pay in full for treatment, at the time services are rendered, receive a 20% discount on those services. Those patients who make a partial payment, co-payment, or ask us to send them a billing statement after their insurance has processed their charges, will not receive the 20% discount on services.

Terms:

1. Pediatric Sensory Therapy reserves the right to choose which insurance companies we will bill. If this office chooses not to bill your insurance, payment is expected at the time service is rendered unless other arrangements are made with this office.
2. If we do not accept your insurance and/or you pay in full at time of services, we can mail claims to your insurance company so you can be reimbursed directly by your insurance. Or we can give you a receipt that you can submit to your insurance company for reimbursement.
3. This office will verify your insurance coverage and provide a written estimate prior to your first visit. This office will make every attempt to obtain accurate verification of your policy coverage (i.e. unmet deductible amounts, co-payments, or percentage of coverage, and services covered by your plan). **However, we cannot guarantee that the information your insurance company gave us is accurate or that your claims will be paid as stated.**
4. This office does not guarantee your insurance will pay for care. If your insurance company denies payment, you are responsible for 100% of billed charges.
5. You are responsible for any charges your insurance applies to your annual deductible. If you have any unmet deductible, you may be required to pay at the time of services, until your deductible is met.
6. You are responsible for any non-covered charges and all amounts not paid for by your insurance for services or supplies provided to you at this office. Payment is expected in full, at time of service, for all supplies or other Home Exercise Equipment devices, as these items are typically not covered by your insurance.
7. If you have a credit balance on your account, after this office receives all insurance payments for all services provided to date, you will received a refund. Or you may use the credit balance for future services or supplies.
8. You are responsible for paying copays at the time of service.
9. Your insurance company should pay within 30-90 days and you will be responsible for paying your portion with in 14 days of receiving a statement of your balance.
10. If your insurance company has not paid within 90 days, you may be required to pay the balance at that time.
11. If you choose to discontinue or dismiss yourself/your child from care without the therapist's authorization, the balance of your account may be due and payable, in full, at the time of discontinuance, even if your insurance claims have been submitted.
12. If, at any time, this office becomes uncertain that your insurance will pay for services rendered, this office has the right to terminate this agreement.
13. If you fail to provide updated insurance information you will be responsible for the full amount billed towards insurance without discount.
14. This office is not obligated to enter a dispute with your insurance company regarding any claims for reimbursement.
15. I understand that this office is HIPAA compliant and may engage in electronic verification or claims processing, but most All claims for services provided at Pediatric Sensory Therapy, will be filed on paper.
16. I authorize the release of any medical or other information necessary to process claims. I also request payment of bills/claims for services furnished to me/my child.
17. I permit a copy of this authorization to be used in place of the original and I have read, understand, and agree to the terms stated above.

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Print Patient/child's Name

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Signature of Parent/Guardian Today's Date