Financial Agreement

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Please understand that we deal with many insurance companies and it is impossible for us to know what your insurance does/does not cover. It is your responsibility to know these coverages. Each employer dictates to the insurance company what it wants covered for its employees and if you have concerns, please discuss your concerns of your coverage with your employer or your insurance company. We are only following through with the information you give us about your insurance company. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initials
* All co-insurance, co-pays and deductibles are expected to be paid at the time of service. The coinsurance is a percentage of the allowed amount and is the patient’s responsibility. We will estimate this until we get the first payment. If there is an overpayment, it will be credited to your account. We know your co-pay amounts and the latest amount due on your deductible at the start of your service based on what your insurance company has told us. This will also show on your copy of the EOB. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initials
* Please remember that benefits change periodically so please inform us of these changes when or if they occur. Additionally it is important to let us know right away if your insurance company changes as oftentimes insurance companies require PRE-APPROVAL or AUTHORIZATION and these take time to obtain; unfortunately, many insurances do not back date authorizations, so you may be responsible for the bill if the office is not notified in a timely manner. \_\_\_\_\_\_\_\_\_\_\_\_Initials
* If you fail to cancel your appointment, you will receive a $50 no-show charge for each discipline scheduled to work with you/your child. Insurance companies do not pay for no-show fees therefore you will be responsible for these fees. After three no shows, you/your child will be discharged from the therapy schedule. \_\_\_\_\_\_\_\_\_\_\_\_\_Initial
* I hereby authorize reimbursement directly to Pediatric MotorWerks Occupational Therapy, LLC and/or Pediatric MotorWerks Physical Therapy, LLC. I also agree that if the insurance company issues payment directly to me for these services, I will pay the amount issued by my insurance company to Pediatric MotorWerks Occupational Therapy, LLC and/or Pediatric MotorWerks Physical Therapy, LLC within 15 days of receiving payment. \_\_\_\_\_\_\_\_\_\_\_\_\_\_Initial
* There is a $50 fee for any returned checks.\_\_\_\_\_\_\_\_\_\_\_\_\_Initial

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_agree to comply with Pediatric MotorWerks Occupational Therapy, LLC and Pediatric MotorWerks Physical Therapy, LLC financial agreement. If I am unable to comply, I understand that further sessions will be withheld until payment is made.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

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Relationship to patient