Financial Policy For Private Insurance/Self-Pay Clientele

Please initial that you understand the stated policies

Billing your Health Insurance Company

As a courtesy to you, Fiesta Pediatric Therapy, Inc. will bill your insurance company directly after each visit. Insurance benefits vary from plan to plan. Therapy services may not be covered by your insurance or may be limited. Therefore it is the patient's responsibility to know their individual coverage. While our billing staff constantly tries to stay current, our office does not have the ability to monitor all rapid changes occurring in today's healthcare environment. We will provide services to your child with the understanding that if any or all of the services are not covered by your insurance, you will accept financial responsibility for the services rendered.

_____ **Verification of benefits is not a guarantee of payment.** It is your responsibility to satisfy your deductible each year by paying the amount directly to us, unless it has been satisfied by payment of other charges. If payment from your insurance company is not received within 60 days of the date of service, payment in full is due immediately or services will be discontinued.

Payment of fees is your responsibility

_____ I am responsible for all fees and I understand I will be charged for all treatment if not paid by insurance carrier. I agree to pay the yearly deductible, and my portion of fees at the time of treatment

_____ I understand and agree that copays/deductibles/co-insurance needs to be paid on the date of service. Copays/deductibles/co-insurance cannot be reduced. A $35.00 late fee will be added for each unpaid copay/deductible/co-insurance.

_____ I understand and agree that returned payments will result in a $50.00 administration fee.

_____ I understand and agree that if an account is sent to collection, Fiesta Pediatric Therapy, Inc. will charge the patient an additional $50.00 fee.

Cancellation of a therapy session (s)

If you need to cancel therapy, please allow more than 24 hours notice unless it is an emergency or serious illness. When cancellations occur on more than an emergency or serious illness basis, and/or you fail to show for treatment, we will bill you directly a charge of $50.00 (private insurance/self-pay clientele only). This is not reimbursable by insurance.

- ✓ Attendance is expected to be at least 75% of scheduled appointments. Two "Failure to Show" appointments will result in an immediate loss of scheduled therapy time slot you can continue to come on a one-time appointment basis.

_____I understand that if I do not cancel a therapy session with at least 24 hours notice, I will be billed a charge of $50.00. This charge is not reimbursable by insurance (private insurance/self-pay clientele only)

Records Release

If records are being disclosed to a party other than another medical facility for the continuing care of this patient, I understand an agree that I am financially responsible for the following fees associated with my request: $45.00 copying fee plus 5 cents per page. Payment is due prior to release of records. We have 21 business days to process your request.

Assignment of Benefits-Authorization to Release Information-Financial Responsibility

I consent to and authorize therapy services. By signing this form, I authorize Fiesta Pediatric Therapy, Inc. to use this signature as authorization of all insurance claim submissions. I authorize payment to be made directly to Fiesta Pediatric Therapy, Inc. I permit a copy of this authorization to be used in place of an original claim form. I understand that I am responsible for all fees incurred. I authorize Fiesta Pediatric Therapy to initiate a complain to the Insurance Commissioner for any reason on my behalf.

Name of Patient (Print): _____

Name of Legal Guardian: _____

Signature: _____ Date: _____