allcare
Therapy Services, LLC
OCCUPATIONAL, SPEECH, PHYSICAL & ABA THERAPY

OFFICE AND FINANCIAL POLICIES

PLEASE INITIAL EACH PARAGRAPH

As of 1/1/24 Allcare Therapy Services will be implementing a new cancellation policy to ensure continued therapy services for your child. We understand and acknowledge that family emergencies and illness do occur; however, we will be requiring 24 hour notice for all cancellations. If you are not able to give 24 hour notice due to illness or an emergency, you will have 30 days to reschedule your missed session. If you do not reschedule your session, you will be charged a $30.00 late cancellation fee. Allcare Therapy Services requires a 90% attendance rate to ensure your child meets his/her goals. If your attendance falls below 90%, your time slot is not guaranteed. Allcare will assist you in finding a time slot that works better for you.

_____ **Payment Responsibility:** I acknowledge full financial responsibility for services rendered by *ALLCARE Therapy Services, LLC*. I must promptly notify the office of any changes in my health care coverage. Exact insurance benefits may not be determined until the insurance carrier receives the claim. I am responsible for prompt payment of charges not covered by insurance, including co-insurance, deductibles, and co-pays. Payment of co-pays is expected at the time of service, and I must also pay any prior balance owed. My insurance carrier may not fully reimburse medical services due to various factors such as usual and customary rates, benefit exclusions, and coverage limits. My insurance coverage depends on my contract with the insurance company. A credit card on file is required to begin or continue services. **I understand that I am responsible for any balances not covered by insurance. I acknowledge that I can contact my insurance carriers about any disputes I may have.**

_____ **Delinquent Accounts:** I understand that my account may be turned over for collection and I will be responsible for all costs of collection monies owed, including court costs, collection and attorney fees. I further understand that if I fail to make any of the payments for which I am responsible in a timely manner, I will be charged a monthly service charge on the remaining balance.

_____ **Attendance and Cancellations: I understand I need to keep a 90% attendance policy in order to maintain my recurring time slot.** I understand that I am required to provide at least 24 hours advance notice if unable to keep a scheduled appointment because the scheduled time slot has been reserved exclusively for me and/or my family members. I am financially responsible for the reserved appointment. If I cannot keep my appointment I will be charged a fee if proper notice is not given. ALLCARE Therapy Services may make exceptions and waive the fee, at its discretion, for emergency or unusual circumstances. I understand that insurance companies do not provide reimbursement for cancelled sessions. **Repeated missed appointments may result in termination of therapy and/or change in recurrence of appointment time.**

_____ **Referrals and Authorizations**: I understand that, I am responsible to obtain all referrals from my Primary Care Physician (PCP) and keep track of how many visits were issued and when they expire. If authorization for office visits is required, I need to keep track of how many visits were issued and when they expire. Any services received without a referral or proper authorization will be my responsibility.

_____ **Returned Check Fee**: I, the undersigned, agree to pay a fee for any check returned by my financial institution regardless of reason.

_____ **Authorization to Release Information: I HEREBY AUTHORIZE Allcare Therapy Services** to release medical information acquired in the course of my evaluation and/or treatment, to my insurance company, other physicians required to participate in my care, or to my child's school district.

I fully understand and agree to the above policies and conditions

Client Name _____

Parent/Guardian Signature _____

Printed Name _____

Date: _____