



## OFFICE AND FINANCIAL POLICIES

### PLEASE INITIAL EACH PARAGRAPH

\_\_\_\_\_ **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 that I need to keep a 90% attendance rate in order to maintain my recurring time slot. I am required to provide at least 24 hours advance notice if unable to keep a scheduled appointment. Allcare Therapy Services, LLC understands and acknowledges that family emergencies and illnesses do occur. If I am not able to give 24 hours due to illness or emergency I will have 30 days to reschedule my missed appointment or I will be charged the late cancellation fee of \$50.00. If I do not show up to my scheduled appointment my credit card on file will automatically be charged the \$50.00 no show fee. **Repeated missed appointments may result in termination of therapy and/or change in recurrence of appointment day/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, LLC** 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: \_\_\_\_\_