OFFICE AND FINANCIAL POLICIES

PLEASE INITIAL EACH PARAGRAPH

__________ **Payment Responsibility:** I acknowledge full financial responsibility for service rendered by ALLCARE Therapy Services, LLC. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including co-insurance, deductibles and co-pays. I understand payment of co-pays is expected at time of service, as well as any prior balance I may owe. I understand my insurance carrier may not approve or reimburse medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, medical necessity, or non-covered evaluations and treatment. **I also understand that my insurance coverage depends on my contract with the insurance company.**

__________ **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: ____