



Helping Hands Pediatric Therapy

470 S. Hill Street; Buford, GA 30518
Telephone: (678) 482-6100; fax: (770) 932-5684

Policy Statement & Financial Agreement

1. **Insurance-** It is the patient/parents(s)/guardian responsibility to inform Helping Hands Pediatric Therapy, Inc. of any and all changes in insurance information, including group policy number, identification number, phone numbers, addresses, etc. as soon as possible. **Failure to do this could result in total patient responsibility for charges incurred.**

The undersigned agrees that in consideration of the therapy services to be rendered to the patient, he/she hereby obligates himself/herself to promptly pay any co-pay, coinsurance, deductible or non-covered service amount due on the date in which services are rendered. Any amount not paid within 3 months of the date of service will be subject to an interest rate of 1% per month and will be subject to collections.

Both private insurers and the Federal Government prohibit waiving and/or reducing the co-payments. Due to binding contracts with each insurance company and industry wide standard ethics, we are required to collect all co-payments and deductibles that are due by your specific policy. We are obligated to be in compliance with these standards.

We require payment at the time of service. However, as a service to our clients, we will file your claims with your private insurance company. **Insurance policies are contracts made between the patient and the insurance company. We will verify your insurance benefits; however this is in no way a guarantee of payment for therapy services. When insurance does not provide payment of therapy costs, payment of the bill is your responsibility. If for any reason treatment is denied by your insurance, we will charge for the usual and customary amount paid by your insurance company.**

A limited number of Medicaid patients are accepted on a space available basis. Prior arrangements for Medicaid patients must be made with Helping Hands Pediatric Therapy prior to services being rendered. The therapist will handle payment arrangements for Medicaid recipients. My signature below indicates authorization for payment to be sent directly to Helping Hands Pediatric Therapy for any claims submitted to an insurance company, Medicaid or Babies Can't Wait (BCW) on my child's behalf.

For patients who have been accepted with Medicaid as a payer, you will only be responsible for services that are denied by Medicaid. These include but are not limited to sessions for which Prior Authorization was requested but denied. **For these services & self pay clients, you will be billed a cash discounted rate of \$130 for 1 hour treatment sessions and \$200 for evaluations. Consultation to parents, teachers, IEP teams, behavior specialists, etc. cannot be billed to insurance payors, so these incur a self pay charge of \$50 per 15 minutes of consult (if travel is required on behalf of the therapist, then a \$15 travel fee is also applicable).**

_____ **Initial that you have read #1**

2. **Cancellation Policy-** We are committed to providing quality consistent services to our clients. Therapy will be most beneficial to your child with **consistent attendance**. It is also important that you **arrive on time** so that your child can benefit from a full session. Routine tardiness may result in billing that time directly to you. If you are more than 15 minutes late for your session, therapy will not be provided. We understand that there will be unavoidable circumstances that may come up. **In order for us to plan appropriately for staff, we require that parents call to cancel their appointment for illness or an unavoidable conflict as soon as possible. Scheduled appointments canceled without notice will be charged a fee equal to one unit of billable treatment missed (minimum of \$30). This is NOT billable to insurance companies or Medicaid and will be billed directly to the patient/family. Patients who are regularly, in the opinion of the treating clinician, more than 15 minutes late to appointments, or who do not attend at least 75% of scheduled therapy sessions, are subject to discharge.** When possible, we will try to reschedule your appointment that week. There are many families that are waiting for services. We appreciate your cooperation with this.

_____ **Initial that you have read #2**

3. For your convenience, Helping Hands Pediatric Therapy allows parents/legal guardians or the caregiver to leave the premises during their child's appointment. However, we highly encourage parent observation of therapy sessions for the purpose of understanding the treatment process and to facilitate follow-through at home and in other settings. If you leave during your child's therapy, **you must be back on the premises 15 minutes before the appointment is scheduled to end** so that the therapist can discuss treatment with you. HHPT must have a cell phone number to reach you before leaving. By signing and initialing below, you agree to give HHPT permission to call 911 or Emergency Medical Services for your child in the event of an emergency. **If you return late to the premises to pick up your child, you will be charged \$1 per minute late.** If HHPT notices chronic tardiness in picking up children, we will begin asking the parent/legal guardian or caregiver to stay during the child's treatment.

_____ **Initial that you have read #3**

4. **Consent to release photo of your child:** We like to display pictures of the children who come to HHPT. Please initial if it is okay for HHPT to display pictures of your child in our brochure, website, advertisement/promotional activities and/or in our clinic.

_____ **Initial that you agree to #4**

This form has been fully explained to me and my signature certifies that I understand its contents and accept the terms.

I authorize the release of my child's requested medical records to my insurance company, Medicaid, BCW, and other HIPAA compliant companies necessary to obtain payment for services involved in my child's care. Requests for medical records to other parties will require approval from the child's parent/guardian prior to release.

Assignment of Insurance Benefits

I, _____, authorize **Helping Hands Pediatric Therapy** to bill for and receive
(Parent/Guardian)
payment for therapy services rendered to _____ from his/her insurance company.
(Child's Name)

Date

Patient and/or Guardian Guarantor Signature

Witness

Print Name