INSURANCE INFORMATION FORM

WE STRIVE TO PROVIDE YOU THE BEST, PERSONALIZED CARE POSSIBLE. TO MAKE THIS POSSIBLE WE ADHERE TO A SET OF VERY IMPORTANT GUIDELINES. PLEASE READ THEM CAREFULLY AND SIGN THEM TO INDICATE YOUR AGREEMENT. WE THANK YOU FOR REVIEWING THESE POLICIES; AND WE LOOK FORWARD TO SERVING YOU AND YOUR CHILD. PLEASE INITIAL NEXT TO EACH ITEM

LATE POLICY "10 MINUTES"

_____BEING LATE BY MORE THAN 10 MINUTES MAY REQUIRE YOU TO EITHER RESCHEDULE OR WAIT FOR THE NEXT AVAILABLE OPENING. IF WE CAN WE WILL ACCOMMODATE YOU, BUT THERE IS NO GUARANTEE WE WILL BE ABLE TO SINCE OPENINGS DUE TO LATENESS OR CANCELLATION ARE UNPREDICTABLE.

COPAYS

_____COPAYS ARE DUE UPON ARRIVAL.

CANCELLATION POLICY

_____24-HOUR NOTICE IS REQUIRED FOR ANY CANCELLED APPOINTMENT. FAILURE TO CONTACT OUR OFFICE WITHIN 24 HOURS MAY RESULT IN $10 CANCELLATION CHARGE. PLEASE KEEP OUR OFFICE PHONE NUMBER HANDY. WE CANNOT BILL THE INSURANCE COMPANY FOR THIS CHARGE. MISSED APPOINTMENTS ARE COSTLY TO THE PRACTICE AS THE THERAPISTS ARE STILL PAID FOR THEIR PAID. THIS COURTESY PROVIDES THE THERAPIST AN OPPORTUNITY TO ADJUST THEIR SCHEDULE TO SEE A CHILD THAT IS ON OUR WAITING LIST. 24-HOUR NOTICE IS REQUIRED TO PREVENT THE $10 CHARGE; HOWEVER A 48-HOUR NOTICE IS REQUESTED. THANK YOU FOR YOUR COURTESY IN FOLLOWING THIS POLICY.

_____REPEATED CANCELLATION OF APPOINTMENTS (MORE THAN 3 WITHIN A QUARTER) WILL BE GROUNDS FOR DISCHARGE. CONSISTENCY WITH APPOINTMENTS IS REQUIRED FOR PROGRESS TO OCCUR. YOUR COMMITMENT TO MAKING APPOINTMENTS IS NEEDED AND REPEATED NO SHOWS WILL RESULT IN DISCHARGE FROM CARE.

CHANGES TO INSURANCE POLICIES

_____IT IS THE RESPONSIBILITY OF THE POLICY HOLDER TO NOTIFY OUR OFFICE OF ANY INSURANCE POLICY CHANGES. MANY THERAPY VISITS NEED PRE-AUTHORIZATION RIGHT AWAY, SO IT IS IMPERATIVE THAT WE HAVE CURRENT INSURANCE INFORMATION OF FILE AT ALL TIMES. FAILURE TO NOTIFY OUR BILLING OFFICE OF ANY CHANGES IN COVERAGE MAY RESULT IN DENIALS AND THE POLICY HOLDER WILL BE INVOICED FOR ANY DENIED THERAPY VISITS.

I have ready and understood the above items. I will follow this payment agreement.

Signature of Guarantor:_____ Date:_____

Patient unable to sign because he/she is a minor (please initial): _____