



FINANCIAL POLICIES

Thank you for choosing Therapedia, LLC. Because healthcare benefits and coverage options have become increasingly complex, we have developed these policies to help you better understand your responsibilities and eliminate any unnecessary confusion. Please carefully read through the following financial information.

UPDATES: Please advise us any time there is any change to your address, telephone or other contact information. If your insurance changes or discontinues mid-treatment, including receiving new insurance cards, please provide us this information immediately so there is no delay in billing.

INSURANCE COVERAGE: As a service to our patients, Therapedia, LLC is more than happy to directly bill your primary insurance for services rendered, but it is our policy that the *patient* is ultimately responsible for payment of the services received from Therapedia, LLC. We do not bill secondary insurance, but upon request will provide you with a receipt that you may submit. Furthermore, the *patient* is responsible for understanding their insurance coverage in relation to covered services.

We make every attempt to verify your current insurance coverage. Verification of benefits is NOT a guarantee of payment. If we contact your insurance carrier regarding benefits or authorization on your behalf, we are not responsible for inaccurate information provided to us by your carrier. The information about your plan that we relay to you is in good faith. Please remember that any changes made to your insurance policy and the time of year billing is submitted may affect coverage and reimbursement rates.

Deductible and co-payments are part of your contractual agreement with your insurance company, and it is our responsibility as participating providers to collect those fees. **Deductible and co-payments are due at each visit.** A refund is issued when an overpayment has been identified. If you feel a refund is due, please contact our office.

NO INSURANCE/CASH RATE: We believe that no one should be denied therapy services secondary to lack of insurance coverage. Our clinic offers a discounted cash rate to those who do not have insurance coverage or elect to not use insurance benefits. Payment will be required at the time of service or before *unless arrangements are made in advance*. Please inquire about our current cash pay rate if it is applicable to your situation.

PAYMENTS: Therapedia, LLC accepts payment in the form of cash, checks, or credit card (VISA, MC, or Discover). Any unpaid balances will be billed to you. A \$30 NSF (non-sufficient funds) fee will be charged for any checks returned to our office because of insufficient funds. If we receive a returned check, we will notify the patient or responsible party immediately and request that a cash payment be brought to our office within 24 hours to replace the amount of the full amount of the check.

COLLECTIONS: If your account is more than 90 days past due, without an established payment plan on file, we will begin immediate collection actions. Your account will be assessed a 35% late fee. If you do not pay your bill following our internal collection efforts, your account will be sent to an outside collection agency. If your account is sent to a collection agency, you will need to contact them directly to settle your balances.

MEDICAID ONLY: Children with an active Medicaid policy can submit that information to Therapedia. We will request authorizations and submit claims to our contracted agencies. Your child's information will be submitted to Medicaid as required to secure payment.

____ (Initial) I understand that, in the opinion of Therapedia, LLC, the services I have requested for my child **may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for their care. I understand that I am responsible for payment of the services requested and received if these services are determined by Medicaid not to be reasonable and medically necessary for my child's care.**

FINANCIAL AGREEMENT: (Initial One)

_____ I elect to have Therapedia, LLC bill insurance for my child's visits. I hereby authorize my insurance benefits to be paid directly to Therapedia, LLC and I am financially responsible for non-covered services.

OR:

_____ I will not be using insurance benefits and elect to pay for services at the cash rate.

I have read and agree to the above information.

Patient name: _____

Signature of Responsible Party (must be over 18 years old) _____
Date