compleatKiDZ

# Payments Policy

FOR LEGAL GUARDIAN USE ONLY

## Parent/Legal Guardian Information

First Name _____ Middle Name/Initial _____ Last Name _____

Relationship to child

☐ Parent ☐ Grandparent ☐ Aunt/Uncle ☐ Sister/Brother ☐ Foster Parent ☐ Court-Appointed Guardian

## Child's Information

First Name _____ Middle Name/Initial _____ Last Name _____ Date of Birth ___/___/___

## Payments Policy

**INSURANCE PAYMENTS**

**1. Insurance:** We participate in most insurance plans, including Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**2. Proof of Insurance:** We must obtain a copy of your insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

**3. Co-payments and Deductibles:** All co-payments, co-insurance payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by making these payments at each visit.

Co-Pay _____ Out-of-Pocket _____ Deductible _____ Auth. Required _____

Coinsurance _____ Visit Limit _____ Total/Appt _____ During your plan year have you been seen elsewhere? ☐ Yes ☐ No

**4. Coverage Changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically become your responsibility to pay.

**5. Non-Covered Services:** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicaid or other insurers.

**6. Claims Submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that, with the exception of Medicaid, the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. It usually takes between 7-14 days from the date of service to receive payment from an insurance company.

**7. Refunds:** At the end of your course of treatment and your insurance company has processed all claims, we will review your account. If you have overpaid your family-responsibility you will be issued a refund of the amount you over-paid.

## SELF-PAYMENT

If you do not have insurance, we do offer private pay rates for individual sessions:

**Occupational and Physical Therapy**
Initial evaluation: $110
Treatment 85$ per hour

**Speech Therapy**
Initial evaluation: $110
Treatment 50$ per half an hour

**Behavioral Therapy**
Psychology Evaluation: $1,800
ABA Evaluation: $160 per hour
ABA Treatment: $72 per hour
Parent/Family Training: $80 per hour

## PAYMENT POLICY

**1. Account Statements:** For rehab services, you will receive a statement each month indicating the status of your account. If a patient-responsibility payment is due, the statement will show the amount. Payment is due upon receipt of the account statement. A payment voucher is included with your account statement. You may use the voucher to mail us your payment, or you may contact your clinic directly, either in-person or via telephone, to make your payment.

For ABA services specifically please contact our ur billing service's customer service line at 704-824-7800, option 4, to receive your account status.

**2. Non-Payment:** If your account is 30 days past due, you will be contacted by our accounts management team to facilitate payment of your balance due. If you have an unpaid balance of $100.00 or more from a previous case, you will not be able to initiate care for a new case until the unpaid balance from the previous case is paid. If you have questions regarding the status of your account, charges reflected on your monthly account statement, and/or family-responsibility payments due, please call our billing service's customer service line at 704-824-7800, option 4, and they will assist you.

## FINANCIAL PLANS

We understand the cost of healthcare can put a strain on finances. t is our policy that payment of the portion owed for services received that are not paid for by your insurance are due on the date of service (deductible, co-insurance, copay).
If you are unable to make full payment of what is owed, we may be able to set-up a deferred payment plan.
Reach out to us at 704-824-7800, option 4

# Financial Authorization

I understand that Compleat KiDZ Pediatric Therapy has verified my child's benefits as a courtesy to me prior to their initial appointment. This authorization is not a guarantee of payment. Any family payment responsibility, such as a deductible, co-pay, or co-insurance, will be collected at the time of service.

## CONSENT FOR ASSIGNMENT OF BENEFITS

- ☐ I hereby authorize Compleat KiDZ Pediatric Therapy to bill my/my child's insurance company, and for my/my child's insurance company to remit payments directly to Compleat KiDZ Pediatric Therapy for services rendered.
- ☐ I have elected to pay for the services rendered to my child by Compleat KiDZ Pediatric Therapy via out-of-pocket payment at the time of service and at the self-payment rates stated in this Payment Policy Notification

I agree to keep an active credit card on file with Stripe that is securely linked to my child's Compleat KiDZ Pediatric Therapy account, knowing that Compleat KiDZ only has access to the last 4 digits of the credit card number. give Compleat KiDZ Pediatric Therapy permission to perform automatic credit card draws using said credit card when my child's account balance meets the criteria stated in this Payment Policy Notification.

# Copy of Insurance Card *Not applicable for Self-Payment*

- ☐ I confirm that I provided a copy of my/my child's insurance card applicable for the requested services.
- ☐ I could not bring the insurance card, but will do so with the next occasion
- ☐ I no longer have my/my child's insurance card

**Parent/Legal Guardian (Print Name)** _____

**Signature** _____

**Date** ___/___/___