FINANCIAL POLICY and CONTRACT

Welcome to Developmental Pediatrics. We are pleased you have chosen us to provide your therapy. We would like to inform you of the policies regarding payment with our office. We accept cash, personal checks and money orders for payment of your account. *If you have no insurance, or have insurance with which we do not contract, you will be expected to pay for your visit in full on the day of your visit. If your insurance is one with which we do contract, you are expected to pay your co-pay/co-insurance at the time of your visit.*

NO INSURANCE: If you have no insurance, we expect you to pay for your visit at the time of service. Your therapist may be able to answer questions about possible financial resources for future therapy.

MEDICAID: We participate in the Medicaid/Model 200 plan for Physical/Occupational/Speech therapy. You must provide us with a copy of your Medicaid card each month to insure no lapse in services. Should services be rendered, and you are no longer eligible for Medicaid coverage, you will be responsible for payment based on our normal fee schedule. All co-pays are to be paid on the day of service.

CONTRACTED INSURANCE: If you have insurance with which we contract (this may be verified from the insurance book given to you by your employer or agent), we will submit your insurance claims for you providing you supply us with the information necessary to do so. This includes a copy of your insurance card, address to submit claims and a telephone number allowing us to verify your coverage. You are still responsible to know the amount of your co-pay and for payment of your co-pay at the time of service and any amounts not covered by your insurance, including deductibles. If coverage is denied for any reason, you are responsible for payment of the entire balance due, based on our normal fee schedule.

A referral or authorization is what you get from your primary care physician that refers you to Developmental Pediatrics for treatment. You (the parent) are responsible for initiating this through your primary care physician prior to us evaluating and treating your child. You are also responsible for keeping track of the number of visits your child has received for each authorization.

AUTO INSURANCE: If your visit here involves an accident related injury we must know the date of the accident, where the accident occurred and the name and telephone number of the adjuster for your claim. We cannot bill your health insurance for accident related injuries. If this information is not provided, or your claim is denied for payment for any reason, you are responsible for payment of the entire balance due based on our normal fee schedule.

NON-PAYMENT: In the event your account becomes delinquent, you will be responsible not only for charges incurred, but also any costs involved in collection of your account. These include, but are not limited to, interest charges, rebilling fees, court costs, attorney fees, and collection costs. Insurance coverage is a matter between you and your insurance company. You are ultimately responsible for the payment of your account.

NO SHOWS: If you fail to show for an appointment without canceling, there will be a $25.00 charge. We keep your appointment open for only your child each week, and can only fill it if we know you won't be attending.

If you have any questions regarding our payment policies, please ask us before your visit. Thank you!

I have read and understand the payment policies set forth and have been given the opportunity to ask questions about this policy. I understand my responsibility for payment of my account with Developmental Pediatrics and to the best of my knowledge have provided accurate and complete information. I also authorize payment of benefits by my insurance company directly to Developmental Pediatrics.

Sign_____Date:_____

Print Name_____