Financial Policy and Agreement

child&familydevelopment

Thank you for choosing us as your specialty care provider. We are committed to quality evaluation and treatment. Please be aware that payment of your bill is considered part of your therapy. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

Payment in full is due prior to your appointment.
We accept cash, checks, or Visa/ MasterCard/ American Express. An insurance card must be shown at each visit in order for the service to be billed to your plan. Insurance will not be filed retroactively.

INSURANCE

We may accept assignment of insurance benefits after your first visit. However, we do require copayments, deductibles, and non-covered charges to be paid at the time of services. Please be aware that some, and perhaps all, of the services provided may not be covered under your particular benefit plan. Any verbal verification of benefits or coverage is never a guarantee of payment. If your insurance company has not paid services in full within 30 days, the balance will automatically be billed to your account. Balances in excess of 30 days must be paid before additional services can be rendered.

MANAGED CARE INSURANCE PLANS

If we are a participating provider, all copays, deductible sand non-covered services are due at the time of service. Managed care plans are complex and most always require pre-authorization for services. If you participate in a Managed Care Insurance Plan, it is imperative that you and our business office communicate prior to scheduling appointments. In the event that your insurance coverage changes, Child & Family Development (C&FD) must be notified prior to the effective date of the new policy. If C&FD is not notified before the effective date, refer to Insurance paragraph.

MEDICAID

C&FD will accept North Carolina Medicaid for PT, OT and ST services with a current Medicaid card and authorization from DMA/DHHS/or other government agency.

Private insurance must be billed prior to accessing Medicaid funds. You must comply with the terms of your private insurance plan in order for the service to be eligible for secondary Medicaid coverage. Unauthorized services or services not billable to Medicaid must be paid in full at the time of service. Medicaid will not be filed retroactively. In the event private insurance coverage changes, C&FD must be notified prior to the effective date of the new policy. If C&FD is not notified before the effective date, refer to Insurance paragraph.

FINANCE CHARGES

A finance charge of 4% per month will be assessed on all balances exceeding thirty (30) days past due.

MINOR CLIENTS

Parents/guardians are responsible for payment. In the case of divorced parents, foster care parents, etc., the adult who arranges for services for the minor is responsible for payment. C&FD is not responsible for billing or collecting from any other party. For unaccompanied minors, treatment will be denied unless charges have been pre-authorized to a Visa/ MasterCard/American Express, or payment by cash or check at the time of service has been verified.

CANCELLATION POLICY

Any appointment cancelled with less than 24-hours notice and not rescheduled will result in a cancellation fee of $35. Repeated cancellations may result in either forfeiture of permanent appointment or termination of service. Failure to contact the office prior to appointment time will result in a no show fee of $50.

I acknowledge primary responsibility for the payment of service to C& FD. I have read, understand and agree to the Financial Policy.

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Guarantor Name

X____

Guarantor Signature

____

Date

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INSURANCE DISCLOSURE AGREEMENT

I have discussed my insurance benefits with a member of Child and Family Development's business staff. I understand the information was provided directly by my insurance carrier and that verification of coverage does not determine claim processing and is not a guarantee of payment.

I agree to the following:

1. Contact my insurance carrier to verify coverage and benefits.

2. Contact my insurance carrier in the event claims are not processed timely.

3. Pay all claims not paid in full by my insurance carrier within 30 days of the date of service.

4. Accept full financial responsibility for all deductibles, copayments, non-covered services and services not billable to insurance. This may include one or more of the following:

- Educational services
- Resources fees
- Books or materials
- Services rendered without diagnosis
- Additional testing or treatment
- Travel time
- Phone consultation
- Parent or teacher conferences

____
Guarantor Name

X____
Guarantor Signature

____
Date

INSURANCE WAIVER (SELF PAY)

I have discussed my insurance benefits with a member of Child and Family Development's business and/or clinical staff. I understand any information was provided directly by my insurance carrier and that verification of coverage does not determine claim processing.

I agree to waive the use of any insurance coverage and pay Child and Family Development directly for any services rendered under this agreement. I understand that services rendered under this agreement will not be filed to my insurance carrier.

I have elected to self pay for the following services provided by Child and Family Development (check all that apply):

O All
O Educational
O Psychological/Psychiatric
O Physical Therapy
O Occupational Therapy
O Speech/Language
O Other ______________________________________

I am aware of my right to access insurance coverage and aware of the formal appeal process for denied services. I have elected not to file for coverage and/or appeal for coverage of these services. This Self-Pay Agreement applies only to the services listed above; another level of care requires a review of benefit eligibility and/or another signed Financial Agreement.

____
Guarantor Name

X____
Guarantor Signature

____
Date