FIDALGO ISLAND PEDIATRIC OCCUPATIONAL THERAPY SERVICES

Child's Name____Child's Date of Birth______________

Contract for Services

I am responsible to confirm that Fidalgo Island Pediatric Occupational Therapy Services is a contracted provider with my specific insurance plan and to verify OT benefits, visit limitations and all plan requirements for Occupational Therapy services. I understand I am responsible to obtain a physician referral and insurance authorization whenever necessary. I will notify Fidalgo Island Pediatric Occupational Therapy Services if prior authorization must be obtained.

I am responsible for payment of any incurred charges denied by insurance because a mandatory physician referral and/or prior-authorization were not obtained.

I am aware that my insurance company may request information to establish medical necessity regarding my child's treatment from Fidalgo Island Pediatric Occupational Therapy Services, and I give my consent for the release of this information.

I am choosing Fidalgo Island Pediatric Occupational Therapy Services to provide occupational therapy services for my child. I understand that if my insurance company does not allow benefits or approve payment of claims for services my child has received, I am responsible for all incurred charges and I agree to pay the balance in full. I understand that I am responsible for payment of my account and to guarantee that the account is paid on a timely basis – whether payments are made by me or my insurance company. If claims are submitted to insurance and payment is not received within 45 days, I agree to follow up with insurance regarding payment. I will keep my account payment current by making regular monthly payments if insurance payment is delayed or denied.

No Show/Cancellation Policy:

I understand, with the exception of illness or emergency, I am required to notify the practice a minimum of 48-hours prior to any cancelled or missed appointments. If I do not provide 48-hour notice, then I will be charged for any missed or cancelled appointments. The cancellation fee is ½ of my hourly rate and the charge cannot be submitted to my insurance.

If you miss more than 5 therapy sessions during a 12-week period, services will be discontinued. If your therapy is scheduled every other week, you may not miss more than 3 sessions in a 12 week period, or services will be discontinued.

Payment Policy Agreement:

I understand that the insurance policy being used to cover therapy services is a contract with the insurance company and is independent from Fidalgo Island Pediatric Occupational Therapy Services. I understand that I am financially responsible for services that the insurance plan does not cover (not applicable with Medicaid insurance). I also understand that I am responsible to notify Fidalgo Island Pediatric Occupational Therapy Services of any changes in insurance coverage. If I do not notify Fidalgo Island Pediatric Occupational Therapy Services of insurance changes or discontinuance, I am fully responsible for any incurred charges.

I have read, understand and accept the terms of the above Contract for Services, No Show/Cancellation Policy and Payment Policy Agreement.

Parent/Guardian/Signature____

Parent/Guardian Printed Name____

Date________________________