



IMPORTANT FINANCIAL INFORMATION

It is important that you be familiar with your insurance coverage for a specific therapy. In order to provide uninterrupted therapy treatment, it is necessary to be aware of what insurance requirements apply to your plan.

As a courtesy to you, our office has contacted your insurance company to see what therapy benefits apply to your plan. **We are not responsible for the information we have received. Benefits are often misquoted over the phone. Final determination of benefits is established when a claim is submitted and either paid or denied. We strongly encourage you to call your insurance company and get information about your plan benefits for therapy.** The contract with the insurance company is between you and that company, our office is not involved.

- **Please notify our office 24 hours in advance if you must cancel.** Patients on our waiting list can be seen when we have these openings.
- **“No-shows” and late cancellations (same day as therapy) adversely affect therapy and are costly to this office. A \$45 “no-show” or late cancellation fee will be charged directly to the patient.**
- **Two “no-shows” may result in loss of your therapy time slot.**
- We will bill your primary insurance.
- Co-pays are due at each visit.
- When we receive payment from your insurance, we will bill you for any outstanding balance. Payment is due upon receipt of your bill.
- Any unpaid patient balances over 60 days will be charged 1 1/2 % interest (18% annually).
- Patient balances unpaid after 90 days will be sent to collection.

If you change insurance plans or companies, please let us know as soon as possible to expedite correct billing. **The final responsibility for your insurance coverage and your therapy bill lies with you.**

Assignment and Release: I understand that I am financially responsible for payment to Children’s Therapy of Woodinville for charges not covered by my insurance company (except for contractual discounts). I authorize Children’s Therapy of Woodinville to release any information to my insurance company that is required for processing of this claim. I hereby authorize the therapy as prescribed by my physician.

SPECIAL PROVISIONS FOR THIS ACCOUNT:

Signature of Parent or Guardian

Date