TherapyWorks 4 Kids, LLC™

Patient Name _____

Financial Authorization & Responsibility

*Initial*_____ I hereby authorize TherapyWorks 4 Kids, LLC to bill my insurance company for direct reimbursement of therapy services rendered to my child. Unless otherwise noted, benefit payment will be assigned directly to TherapyWorks 4 Kids, LLC. I agree to let TherapyWorks 4 Kids, LLC release any medical record**s or information regarding the diagnosis, treatment or condition of the patient named to insurance companies or liable third parties. All copays and payments are due at the time of service. I understand that patient/patient's responsible party is responsible to pay all fees accrued for services rendered, regardless of insurance verification or anticipated insurance coverage, if insurance company refuses to pay provider a portion of the fees or in full. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from patient/patient's responsible party.** I agree to pay all fees within 30 days after bill has been mailed, and understand that any fees not paid within 30 days will result in a 10% or greater late fee. In the event of a returned or invalid payment, as well as an unpaid balance over 90 days, I agree to pay any and all additional associated banking, legal and/or collection fees. I understand that I am advised to fully know and understand my insurance benefits prior to my child receiving therapy services. I understand that all insurance plans are different and it is impossible for TherapyWorks 4 Kids, LLC to know the specifics of my plan and/or if my plan will reimburse for services received. I agree to notify TherapyWorks 4 Kids, LLC if my insurance coverage changes. I understand that I am ultimately responsible for payment of all services received.

*Initial*_____ I am aware that not all fees are billable to insurance companies such as materials, books, equipment, school conferences, and therapist consultations (in person or phone) and will be billed directly to the responsible party or guardian. I understand that I am responsible for payment of these services not billable to my insurance company.

Insurance Information *(please bring all insurance cards at time of visit)*

Patient (Legal Name) Last _____First _____MI _____ DOB _____

Primary Insurance Information:

Insured's Name (who has policy) _____ Insured's DOB _____

Insurance Company Name _____ Ins ph # (on back of card) _____

Provider ID# _____ Group # _____

Secondary Insurance Information:

Insured's Name (who has policy) _____ Insured's DOB _____

Insurance Company Name _____ Ins ph # (on back of card) _____

Provider ID# _____ Group # _____

Tertiary Insurance Information:

Insured's Name (who has policy) _____ Insured's DOB _____

Insurance Company Name _____ Ins ph # (on back of card) _____

Provider ID# _____ Group # _____

*Initial*_____ I authorize that I have listed all insurance companies and I will update TherapyWorks 4 Kids when I have an insurance change. I will be responsible for any claims not paid/not paid in full due to incorrect insurance information. I will be responsible to pay an additional $10 per claim for any claim that needs to be re-filed or appealed due to incorrect insurance information OR any insurance changes that result in reprocessing.

Parent/Guardian(print): _____ (signature): _____ Date: _____