

Financial Policy

Fees: We will always inform you of the changes prior providing any type of clinical service. A schedule of fees can be obtain at any time.

Payment Responsibility: The patient or his legal representative is ultimately responsible for all charges incurred. The payment for services is due each session or on the last scheduled session of the month. The person who brings the patient to therapy is responsible for the payment. Please make all checks payable to **Play With Words LLC**. A Credit Card on File Policy form must be completed in order to charge treatment sessions to your credit card. A copy of the credit card and the parent/guardian driver's license must accompany the Credit Card on File Policy form. There will be a \$40.00 charge for all returned checks and denied credit cards. Your statement at the end of the month is your receipt. _____ (initials)

Partial Insurance Coverage: Health plan coverage is an arrangement between the patient and health plan. Clinicians provide necessary documentation, but **all charges are ultimately the patient's or client's responsibility**. Patients with insurance policies that cover only a portion of treatment must pay their deductibles, co-pays, and or co-insurance amounts that may be due between the contracted allowed amounts and the anticipated insurance payment. This payment is due at the time of service or on your child's last session of the month. _____ (initials)

Late Cancellation, "No Show", and Late Patient Pickup charges: All appointments not canceled by 8:00am on the day of the scheduled session will result in a charge for the full amount of the scheduled session. Late pickup fee is \$25 for the first 5 minutes and \$10 for each additional 5 minutes. Play With Words LLC cannot accommodate children left unattended. Therapists **must** go on to the next scheduled appointment. Late pickup policy is firmly reinforced. _____ (initials)

Uninsured Patients / Non-covered Services: Payment for all charges which are not covered by insurance are due and payable at the time of service or at the patient's last session of the month. If the last session is canceled, it is the patient's responsibility to mail in the payment due so that it is received by the end of the month. All account balances not paid in full within 45 days will be sent to our collection agency, diversified, for further review. _____ (initials)

Unpaid Insurance Balances: Patients/parent or guardian will be requested to make full payment of unpaid balances when insurance payments are not received after 60 days from date of billing. Account balances not paid in full within 60 days will be sent to our collection agency, diversified, for further review. _____ (initials)

Payment Methods: The following payment methods are accepted: Cash, Check, Cashier Check, Money Order, Visa, MasterCard, and Debit Card. _____ (initials)

Refunds: Overpayments will be refunded to the appropriate party in the form of a check. Patient refunds will not be processed until all active or past due balances are paid in full.

I have read and understood this financial policy and have received a copy as well.

Patient/Parent/Responsible Party

Date