

Financial Policy and agreement

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

Payment in full is due at the time of service. We accept cash, checks, or Visa/MasterCard. 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.

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. Go Your Own Way, Inc. 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, or payment by cash or check at the time of service has been verified.

Managed care Insurance Plans

If we are a participating provider, all copays, deductibles and 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, Learning Charms must be notified prior to the effective date of the new policy. If Learning Charms is not notified before the effective date, refer to Insurance paragraph.

In the event private insurance coverage changes, Learning Charms must be notified prior to the effective date of the new policy. If Learning Charms is not notified before the effective date, refer to Insurance paragraph.

Usual and customary rates

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for payment regardless of an insurance company's determination of usual and customary rates.

Cancellation Policy

Any appointment cancelled with less than 24-hours notice and not rescheduled will result in a cancellation fee. 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.

I acknowledge primary responsibility for the payment of service to GO YOUR OWN WAY, INC.. I have read, understand and agree to the Financial Policy.

Guarantor Name _____

Guarantor Signature _____

Date _____

Insurance Disclosure Agreement (for clients who are using insurance benefits) :

I have discussed my insurance benefits with a member of Go Your Own Way, Inc.'s , DBA: Learning Charms' 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:

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

Guarantor Name _____

Guarantor Signature _____

Date _____

Insurance waiver (self Pay)

I have discussed my insurance benefits with a member of Go Your Own Way, Inc.'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 Go Your Own Way, Inc. 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 Go Your Own Way, Inc. (check all that apply):

- All
- Occupational Therapy
- Speech/Language
- 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 _____

Guarantor Signature _____

Date _____