2021 PAYMENT POLICY

Thank you for choosing A to Z Pediatric Therapy, LLC for your therapy needs. This is an agreement between A to Z Pediatric Therapy, LLC and you for payment of services provided. By signing this agreement, you are agreeing to pay for services provided to you or your family member.

Please read the following information carefully.

A to Z Pediatric Therapy, LLC is currently in-network with AETNA and BCBS and accepts SSI Medicaid and the Katie Beckett/Deeming Waiver. We are out-of-network with other insurance companies at this time and are considered an out-of-network provider.

Payment:

- All co-payments are due at the time of visit. All co-insurances and unmet deductibles are due at the time of visit. For example, if patient responsibility is $100.00 per session (as determined by individual policies), A to Z Pediatric Therapy, LLC will collect the patient responsibility at each visit until the deductible or out of pocket maximum is met. *Please note, an individual Notification of Benefits will be provided per client detailing your patient responsibility. For any questions, consult with A to Z Pediatric Therapy, LLC.
- If you are privately paying for services, you will be responsible for paying for services at the time of your child's visit.
- All balances are due prior to the next scheduled visit.
- We are happy to consider other payment arrangements, if needed. Please plan ahead of time to make payment arrangements. Please do not wait until you are unable to pay to discuss with us.

_____ **Initial**

Cancellations & No Shows:

- Please call us or email at least 24 hours in advance to cancel your appointment. A to Z Pediatric Therapy, LLC reserves the right to charge a fee for any appointment that is not kept or not canceled by giving 24 hours advanced notice. If you fail to follow these policies, you may be subject to a fee. We understand that unforeseen circumstances

occur will be dealt with on a case by case basis. The late cancellation/no show fee is $50.00 per missed date of service. Insurance will not cover this fee. Repeated cancellations and/or absences may result in loss of a regular therapy slot.

_____ **Initial**

Insurance or Waiver of Insurance:

If you are Private Pay and not using insurance:

_____ **Initial** I do not wish to file with insurance at this time and will adhere to the Private Pay Agreement document.

If you wish for us to file to your Insurance:

_____ **Initial** I acknowledge that A to Z Pediatric Therapy, LLC is an in-network provider with AETNA, BCBS, and Georgia Medicaid (SSI, Katie Beckett Waiver), but is not contracted with UHC, Humana, or CIGNA, or CMO Medicaid (Peach State, Amerigroup, Well Care, CareSource).

_____ **Initial** I acknowledge that a verification of benefits is not a guarantee of coverage, as they relate to therapy services. I recognize that therapy services may or may not be covered by my insurance company; and that each policy is different regarding allowed services, deductibles, copays, coinsurances, etc.

_____ **Initial** I recognize that referrals and pre-authorizations do not guarantee coverage of therapy services.

_____ **Initial** I am responsible for payment of charges for services rendered by A to Z Pediatric Therapy, LLC. As a convenience, A to Z Pediatric Therapy, LLC will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.

_____ **Initial** It is my responsibility to provide accurate insurance information and notify the office of any changes should they occur. Failure to divulge or misrepresent all active insurance policies will result in the full charge amount being my responsibility.

Returned checks/Past Due Accounts:

- You will be charged a $30 fee for each returned check.

- You are expected to pay your balance in full upon receipt of invoice and/or statement. Accounts not paid by the due date will be considered past due and will be charged a 10% late fee every 30 days.
- Accounts 2 months past due will be sent to a collection agency or filed with small claims court. You will be responsible for collection costs, as well as attorney fees and court costs. There will be an additional charge of 35% of the balance owed for any past due balance that is submitted to an outside agency for collections. Additional fees will apply if legal action is required.

_____ **Initial**

I understand that I am financially responsible for all services provided by A to Z Pediatric Therapy, LLC. I understand that I may receive an invoice for services rendered. I agree to pay the balance in full upon receipt of the invoice.

_____ _____

Print Patient's Name **Date**

_____ _____

Parent/Guardian Signature **Relationship to Patient**