Bright Skies Therapy Center, LLC

Financial Policy and Patient Financial Agreement

Bright Skies Therapy Center is committed to serving our patients with care and professionalism and from our patients we expect the same commitment. This includes financial responsibility. Your responsibility is to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers. Current identification and insurance benefit cards are to be presented at each office visit. As a courtesy, Bright Skies Therapy Center will file your insurance claim for you.

Patient Financial Responsibility Contract

Please read, initial each blank and sign where indicated – this document describes your financial responsibilities. This is a legally binding contract between Bright Skies Therapy Center, LLC and you. The words, I, me, my, you and your all refer to the patient/parent/guardian.

_____ (initial) I agree to be financially responsible for payment of Bright Skies Therapy Center's services. Cash, check or credit cards are acceptable forms of payment for these services. Payment is expected within 30 days of the invoice date. After 30 days the client's credit card on file will be billed for any remaining balance.

_____ (initial) Current insurance cards must be presented at every office visit. Bright Skies Therapy Center is not responsible for filing your insurance claim, but as a courtesy we will do so. Insurance can take 2-4 weeks to process. Once we have received an Explanation of Benefits (EOB) from your insurance company you will be sent an invoice for the remaining balance due.

_____ (initial) I agree to give Bright Skies Therapy Center, LLC my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that if I fail to give complete and accurate information about my insurance benefits this may result in a denial of my claim or a delay in payment.

_____ (initial) I agree that if my insurance benefit requires me to provide a referral and if the referral is not in place before my appointment, that I will pay in advance an estimate of charges for my office visit or reschedule my appointment.

_____ (initial) I understand there will be a $25.00 fee for all returned Checks

_____ (initial) I understand that my insurance may or may not agree to the usual, customary or reasonable charges for my local area. I understand that my benefits may not cover all services or might deny payment for services that have been approved of in advance. Quoted benefits are not a guarantee of benefits, the client is ultimately responsible for verifying their own insurance benefits.

_____ (initial) If I have a high deductible policy or do not currently have insurance benefits, I agree to pay an estimate of charges for my office visit in advance and understand that other charges may apply.

_____ (initial) Bright Skies Therapy Center, LLC has a contract with my insurance company. Bright Skies Therapy Center, LLC will receive payments from my insurance company for covered services provided by my insurance benefits. I agree to pay co-payments and deductibles at the time of service. If co-payments are not made at the time of service, I understand that my appointment may be rescheduled.

_____ (initial) I agree to pay any balance remaining on my account for any reason upon receipt of a statement and I understand that when requested, I must give Bright Skies Therapy Center, LLC my current address and other contact information. I understand that if I fail to pay the balance on my account this may result in Bright Skies Therapy Center, LLC pursuing any collection means possible.

_____ (initial) If my account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.

I have read and I understand Bright Skies Therapy Center, LLC financial policies and I accept responsibility for the payment of any fees associated with my care.

_____ _____

Patient Signature Date

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of medical benefits, including medical benefits to which I am entitled to Bright Skies Therapy Center, LLC. This is a DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS. A copy of this authorization is as valid as the original document. I authorize the release of any medical information necessary to in order to obtain payment and I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collection charges considered patient responsibility by my insurance company. I understand that if I am not insured I am responsible for the charges of all services provided to me. I authorize Bright Skies Therapy Center, LLC to deposit checks received on my account when made out in my name. I have read and I understand Bright Skies Therapy Center's financial policies and I accept responsibility for the payment of any fees associated with my care.

_____ _____

Patient /parent/guardian Signature Date

_____ _____

Witness Signature Date

Acknowledgment of Risk:

I acknowledge that there is some inherent risk in the use of the therapy equipment at Bright Skies Therapy Center. I agree to indemnify and hold Bright Skies Therapy Center harmless from any and all losses and claims for any injuries or other damages occurring to myself, my child, or our belongings, from the use of therapy equipment. I acknowledge that I have read and understand the above outlines policies. I recognize that I will be held responsible for abiding by these policies while my child receives services at Bright Skies Therapy Center, LLC and failure to do so may result in discontinuation of services at this facility.

_____ _____

Signature of Parent or Guardian Date

_____

Printed Name of Parent or Guardian