KIDS FIRST PEDIATRICS

growing families one kid at a time

Therapy Office and Financial Policy

Our goal is to provide and maintain a good therapist-patient relationship. Letting you know in advance of our therapy policy allows for a good flow of communication and enables us to achieve our goal. Please read carefully and initial and sign below. If you have any questions, do not hesitate to ask a member of our staff.

Appointments

1. We value the time that we have set aside to see and treat your child. Therapy appointments are not double-booked. If you are not able to keep your appointment, we require a minimum 24 hour notice. There is a charge of $100 for therapy appointments not canceled within 24 hours.
2. If you are late for your appointment (>15 minutes) we will do our best to accommodate you. However, the ending time of your therapy may not be able to be extended to accommodate the entire therapy appointment.
3. If you have repeated late cancellations or no show appointments, we may not be able to provide therapy services.

Initial:_____

Insurance Plans

Please understand

1. It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit.
2. It is your responsibility to understand your benefit plan with regard to covered therapy and mental health services.

Initial:_____

Financial Responsibility

1. According to your insurance plan, you are responsible for co-payments, deductibles, and coinsurances
2. Co-payments are due at the time of service
3. Self-pay patients are expected to pay in full at the time of visit.
4. If previous arrangements have not been made with our office, any balance outstanding for longer than 90 days will be forwarded to a collection agency.
5. We accept cash, checks, Visa, and MasterCard and debit cards
6. A $20 fee will be charged for any checks returned for insufficient funds.

Initial:_____

After Hours

1. If you or your child is having a mental health crisis, please call 911 or go to the nearest emergency room.

Initial:_____

I have read and understand this therapy office and financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient name:_____

Responsible Party's Name_____ **Relationship**_____

Responsible Party's Signature_____ **Date**_____