HELPING HANDS
PEDIATRIC THERAPY

22 Buford Village Way, Suite 229; Buford, GA 30518
Telephone: (678) 482-6100; fax: (770) 932-5684

Policy Statement & Financial Agreement

1. **Billing the Designated Funding Source & Payment Responsibilities-** As identified in your child's IFSP, this company will bill for therapy services rendered to the appropriate funding source (Babies Can't Wait, private insurance or Georgia Medicaid). In the event that the parent declines access to insurance, the parent agrees to pay their family cost participation percentage as identified in the IFSP. If services are covered by insurance and there is any co-pay, coinsurance, or deductible, then the family is not required to cost participate: in this case, Babies Can't Wait will pay for services in full. If the parent has a payment responsibility, an invoice will be mailed on a monthly basis. If any amount is not paid within 3 months of the date of service, therapy services will be put on hold until payment is made in full.

   It is of utmost importance for parents to inform Helping Hands Pediatric Therapy, Inc. of any and all changes in insurance information or Medicaid eligibility. In most cases, authorization or notification is required for coverage of therapy prior to services being rendered. Failure to inform the company of these changes may result in non-coverage of therapy services.

   As specified in the IFSP, we will bill Babies Can't Wait, your private insurance company, or Medicaid for therapy services rendered. Please note that **Insurance policies are contracts made between the patient and the insurance company. We will verify your insurance benefits; however this is in no way a guarantee of coverage for therapy services. When insurance does not provide coverage of therapy costs, you will be required to cost participate in payment for services, as indicated in your child's IFSP. If for any reason treatment is denied by your insurance, you are responsible for the family cost participation percentage based on the state Medicaid rate for reimbursement.**

   My signature below indicates authorization for payment to be sent directly to Helping Hands Pediatric Therapy for any claims submitted to an insurance company, Medicaid or Babies Can't Wait (BCW) on my child's behalf.

_______Initial that you have read #1

2. **Attendance & Cancellation Policy-** We are committed to providing quality consistent services to our clients. Therapy will be most beneficial to your child with consistent attendance. It is also important that you have your child ready & prepared for a scheduled session with your therapist, so that your child can benefit from a full session. We understand that there will be unavoidable circumstances that may come up. In order for us to plan appropriately for staff, we require that parents call to cancel their appointment for illness or an unavoidable conflict as soon as possible. Whenever possible, the therapist will try to reschedule your appointment that week.

_______Initial that you have read #2

3. **Consent to release photo of your child:** At times, we like to display pictures of the children who receive services through HHPT. Please initial if it is okay for HHPT to display pictures of your child in our brochure, website, advertisement/promotional activities and/or in our clinic.

_______Initial that you agree to #3

This form has been fully explained to me and my signature certifies that I understand its contents and accept the terms.

I authorize the release of my child's requested medical records to my insurance company, Medicaid, BCW, and other HIPAA compliant companies necessary to obtain payment for services involved in my child's care. Requests for medical records to other parties will require approval from the child's parent/guardian prior to release.

Assignment of Insurance Benefits

I, ________________________________, authorize **Helping Hands Pediatric Therapy** to bill for and receive
(Parent/Guardian)
payment for therapy services rendered to ____________________________ from his/her insurance company.
(Child's Name)

_____________________________ ____

Date **Patient and/or Guardian Guarantor Signature**

_____________________________ ____

Witness **Print Name**