Amaryllis
THERAPY NETWORK

Financial Policy and Agreement

Thank you for choosing Amaryllis Therapy Network. We look forward to working with you and your child to meet your child's therapeutic needs. In that effort, we have developed a financial responsibility policy to avoid any misunderstanding and to ensure timely payment for therapy services. Our practice firmly believes in honesty and transparency. If you have any questions, please call our office at 303.433.0852.

Acknowledgement and understanding of this financial policy must be signed prior to starting therapy.

PAYMENT IS DUE IN FULL AND EXPECTED AT TIME OF SERVICE

We accept cash, personal checks, debit cards, Visa and Master Card, HSA and FSA cards

By initialing all items below, you agree that you have read and acknowledge that:

_____ **Payment is required at the time services are rendered:** This includes but is not limited to: co-payments, co-insurance, non-covered and/or unauthorized services, denials for no coverage/eligibility, late-cancellation and no-show fees.

_____ **Private-Pay Accounts:** If you do not have insurance, please come prepared to pay for your visit in full. Amaryllis Therapy Network offers a discounted rate for all private-pay services paid in full on the day of the visit.

_____ **Divorce:** In the case of divorce or separation, the parent authorizing treatment for a child/children will be the parent responsible for paying for those charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

_____ **Co-pays, Co-Insurance and Deductibles:** We are required by our insurance contracts to collect all co-pays at the time of service. Failure to collect co-pays, co-insurance and deductibles puts the responsible party and Amaryllis Therapy Network in breach of the insurance contract.

_____ **Returned Check Fee:** There is a $34 fee for any checks returned by the bank. Cash or credit card payments will be required for any account with more than one returned check fee in a twelve-month period.

_____ **Late-Cancellation and Missed Appointment Fees:** Late-cancellations and no-shows will be subject to a $50 cancellation fee. This fee must be paid in full within two (2) weeks of the missed appointment. This fee is to be paid out-of-pocket and is not covered by insurance. Please refer to our attendance policy for more details.

_____ **Change of Insurance/Change of Address:** It is the responsibility of the parents to notify the front desk as soon as possible of all insurance and address changes. Any delay in updating information may result in denied payment for services that are provided prior to receiving the updated information. Payment for denied services will be billed to you directly.

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_____ **In-Network Insurance:** As a courtesy to our patients, Amaryllis Therapy Network will file claims to any insurance carrier with whom we are a participating provider. **It is the responsibility of the cardholder to know what their eligibility and coverage is with their insurance carrier.** Please verify coverage limitations prior to your child's appointment date. Although we may estimate what your insurance company will pay, it is the insurance company that makes the final determination of your child's eligibility and the amount that will be paid. You agree to pay any portion of the charges not covered by your insurance.

_____ **Out-of-Network Insurance:** If we are out-of-network with your insurance company, full payment of service is due the day of service. We will submit a claim on your behalf as a courtesy. Depending on your insurance plan, out-of-network benefits may be payable after your deductible is met. Some carriers will reimburse you directly, while others will reimburse the clinic. If the clinic is reimbursed, the amount will be credited to your account and future payments for services will be adjusted accordingly.

_____ **Statements:** If you have a balance on your account, we will send you a monthly statement. If your account becomes past due, we will take the necessary steps to collect this debt. Unless other arrangements are pre-approved by Amaryllis Therapy Network in writing, the balance of your statement is due within thirty (30) days from the statement date. If you feel that your claim was unfairly denied by your insurance company, it is the parent/guardian's responsibility to pursue the insurance company on their child's behalf.

_____ **Outstanding Balance:** If your insurance provider has paid their portion of your bill and there is an outstanding balance owed, Amaryllis Therapy Network will notify you via phone, email and/or mail. If your outstanding balance is not paid in full by the statement due date, any balance owed will be charged to your credit card. A copy of the charge will be sent by email or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

_____ **Collections:** If we must refer your account to a collection agency, you agree to pay all costs that are incurred. All accounts sent to the collections agency will be reported to the Credit Bureau.

_____ **Effective Dates:** Once you have signed the financial policy, you agree to all the terms and conditions contained herein, and the agreement will be in full force and effect.

By signing below, you indicate that you understand that you are ultimately responsible for the payment of your bill. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is your responsibility to know your benefits.

Child's Name:_____
(Please Print)

Parent/Guardian's Name:_____
(Please Print)

_____ _____
Parent/Guardian's Signature Date