

Bothell Pediatric & Hand Therapy
18504 Bothell Way NE
Bothell, WA 98011

RE: (Patient's Name) _____ Date of Birth: _____

Contract for Services

I understand that as a courtesy, *Bothell Pediatric & Hand Therapy (BPHT)* has contacted my insurance company to see what therapy benefits apply to my plan. As benefits are often misquoted over the phone, I do not hold *Bothell Pediatric & Hand Therapy* responsible for the information received. Final decision on benefits is determined when a claim is submitted and either paid or denied. I understand that I am responsible to confirm that *Bothell Pediatric & Hand Therapy* is a contracted provider with my specific insurance plan and to verify the benefits allowed for Occupational, Speech Language Pathology, Physical Therapy or Massage services. The contract with the insurance company is between the company and me; *Bothell Pediatric & Hand Therapy* is not involved and does not accept responsibility for negotiating settlement of a disputed claim. In addition, we will not await payment/resolution from third party liability carriers or from a carrier with whom *Bothell Pediatric & Hand Therapy* does not hold a contract for the date of service.

I understand that I am responsible to obtain a physician prescription for all services and my insurance company may also require a referral and/or insurance authorization. I understand that it is my responsibility to keep track of the number of visits used relative to those authorized, the expiration date of any authorization and/or the contract limitations of my insurance plan. If progress reports and/or treatment plans are required by my physician or insurance company, I will notify my therapist at least one month before they are due, to allow time for completion of the paperwork. If insurance is billed by *Bothell Pediatric & Hand Therapy*, my insurance company may request information regarding my child's treatment and I give my consent for the release of this information.

- Insurance co-pays are due at the time of service.
- I understand that I am responsible for payment of my account on a timely basis, whether payments are made by me or by my insurance company.
- If claims are submitted to insurance and payment is not received within 45 days, I agree to follow up with the insurance company regarding payment and personally make regular payments to *Bothell Pediatric & Hand Therapy* on my account.
- All charges are due in full within 60 days from date of service unless a separate payment arrangement has been approved and signed by both *Bothell Pediatric & Hand Therapy* and myself.
- In the event that my insurance company denies payment, I am fully and directly responsible for the payment of all charges. My portion of the bill is due upon receipt of the statement.
- Any unpaid patient balances over 60 days will be charged 1_% interest (18% annually).
- Patient balances unpaid over 90 days will be sent to collections.

As part of ongoing therapy services, the treatment sessions are billed to insurance at \$160 per hour for Occupational and Physical Therapy sessions and \$130 for Speech Language Therapy sessions. A cash discounted rate is available at \$120.00 per hour for Occupational and Physical Therapy and \$110 for Speech Therapy, if paid at the time of service. Evaluations are billed at \$290 to insurance for Occupational and Physical Therapy and discounted to \$240 for patients' cash pay price, if paid at the time of service. Evaluations are billed at \$220 to insurance for Speech Language Pathology and discounted to \$180 for patients' cash pay price, if paid at the time of service. Evaluations for Hand Occupational Therapy are billed at \$170 to insurance plus procedures and splinting done by the therapist, and are discounted 15% for patients' cash pay price, if paid at the time of service.

Parent/Guardian Signature _____ **Date** _____

Insurance Waiver

(Signature required by all insured clients – if claims are or are not submitted)

I understand that my insurance company may not consider the Occupational, Speech Language Pathology, Physical Therapy or Massage services provided by *Bothell Pediatric & Hand Therapy* to be a covered medical expense.

I understand that even when Occupational, Speech Language Pathology, Physical Therapy or Massage services are listed as being a covered medical expense on my insurance plan, payment is not guaranteed. Upon receipt of claims for services rendered, my insurance company will complete a review for medical necessity and based on that review (related specifically to my child) the services *may not be considered to be medically necessary or may be considered as non-covered expenses* and may not be paid by my insurance company.

I elect to have *Bothell Pediatric & Hand Therapy* provide Occupational, Speech Language Pathology, Physical Therapy or Massage services for myself/my child (circle). I understand that if my insurance company does not allow benefits or approve payment of claims for services I/my child have/has received, *I am responsible for all incurred charges and I agree to pay the balance in full.* I hereby authorize payment from my insurance company directly to *Bothell Pediatric & Hand Therapy* for services provided.

Parent/Guardian Signature _____

Date _____

Cancellation Policy

Please notify our office 24 hours in advance if you must cancel your appointment. Patients on our waiting list can be seen when we have these openings.

- “Late cancellations” (cancellations LESS than 24 hours prior to the scheduled therapy visit) are costly to our office and will be assessed a \$50.00 fee, charged directly to the patient.
- “No-Shows” (appointments not held by the patient, with no call made to our office to notify of cancellation of the agreed upon appointment) will be charged at the cash pay rate of \$120.00 directly to the patient.
- Two “No-shows,” and/or numerous “Late Cancellations” and “Late Arrivals” may result in loss of your therapy time slot.
- Appointments missed more than 2 weeks in a row within a 6-month period (i.e. for vacations or other reasons) will result in loss of your therapy time slot. If a patient will be gone more than 2 weeks in a row and you want to keep the spot/s, you can choose to cash pay for those visits you will miss in order to reserve your spot.

It is not our intention to cause undue hardship; however we must collect our receivables as efficiently as possible in order to continue our service to the community.

I have read and understand the *Cancellation Policy for Bothell Pediatric & Hand Therapy.*

Parent/Guardian Signature _____

Date _____