Kid O'Therapy, LLC
41 Main Street
Topsham, Maine 04086
P: (207) 844-8287
F: (207) 844-8245

FINANCIAL POLICY

We are committed to providing you with the best possible therapy services. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. Kid O' Therapy, LLC participates with a variety of insurance plans. It is your responsibility to:

a. Bring your current insurance card to every visit.

b. Check with your insurance company regarding therapy coverage, deductibles, copayments, and preauthorization's and fully understand your insurance policy.

c. You are prepared to pay your co-pay / outstanding balance at the beginning of each visit, even If the responsible financial party is not present at the time of services. (You have an option to keep a credit card on file for making payments if the financial party is not present at the time services are rendered).

d. If your therapy is not covered by your insurance, or if you have no insurance, payment in full is expected at the time of the visit.

2. If we do not participate with your insurance, upon request we can provide you with a form that you can submit to your insurance company. Payment is still expected at the time of service.

3. If you have a secondary insurance coverage, you must provide that information on the date of service. If you do not provide us with your secondary insurance information, in order to file a timely claim, or your secondary insurance has expired, the balance will be your responsibility.

4. Referrals: It is your responsibility to contact your physician and bring any required referrals with you to the first visit. If you do not have a referral for services, you may be financially responsibility.

5. For minors (under the age of 18), the parent or guardian must sign below. The parent/guardian, or unaccompanied minor is responsible for any payment due at the time of services.

6. If you have any questions about insurance, we will do our best to help you. Specific coverage issues should be directed to your insurance company customer service department (the number is on your insurance card).

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7. If you fail to show up for an appointment without contacting us 24 hours in advance, your account will be charged a no-show charge of ($50.00). Office Visit Charge on the first cancellation, a **$75.00** Office Visit Charge on the second cancellation, and a **$100** Office Visit Charge on their third cancellation. This charge **CANNOT** be billed to insurance or applied toward a deductible. This fee must be paid before the next scheduled appointment. This is not covered by your insurance. If you no-show three sessions, the therapist reserves the right to discharge you from their caseload.

8. If you fail to make a payment towards your account balance for the services rendered within 120 days of your last date of service your outstanding balance will be sent to a collection agency or small claims court. By signing below, you agree to be responsible for all fees assessed by the collection agency, as well as, all legal and/or attorney fees for Kid O' Therapy, LLC should you fail to make payments in full for the services rendered. We will make every attempt to work with you, so this does not occur.
9. If you have a high deductible insurance plan and have not reached your deductible, we will collect $100.00 per session, prior to treatment, and balance bill the remainder once we have received the explanation of benefits from the insurance company and credit any difference owed.
10. It is the patient's responsibility to make sure they provide Kid O' Therapy with the correct insurance information in a timely fashion so we can file a timely claim. If your insurance information changes you will notify Kid O'Therapy, LLC immediately so we can bill your insurance properly. Failure to provide information will result in patient responsibility for balances owed.

We believe that a good therapist-patient relationship starts with good communication and understanding. If you have questions or concerns about his financial arrangement, please address them prior to beginning therapy. We will do our best to help you work through this process.

Please sign that you have read and agree to the Financial Policy. In doing so, you agree that you are capable of understanding the information presented as demonstrated by any discussion and responsible nature and participation with reviewing this policy. I have had the opportunity to ask questions and have had them clarified. You acknowledge that you understand your financial responsibility covered in this policy.

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Signature of Patient or (Guardian if under 18)

Date