



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

## Payment Agreement

Thank you for choosing Kid O'Therapy, LLC as your rehab provider. To receive services from us, you agree to the following Payment Policies:

- **Payment Terms.** You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved. Payment for copays, coinsurance and deductibles is expected at the time of service or within 30 days of receiving our bill unless you have made other payment arrangements with us.
- **Medicare.** If you have Medicare and your services are medically necessary covered benefits, we will bill Medicare or your Medicare Advantage Plan on your behalf. You will only be responsible for your co-insurance or co-pay portion of the visit. If at any time we believe your services might not be covered by Medicare, we will discuss this with you and have you sign an "Advanced Beneficiary Notice" indicating whether you want to receive and pay for the services yourself if Medicare doesn't pay.
- **In-Network Claims.** If we are in-network with your health plan, we will submit the claims to your health plan on your behalf and your health plan will send payment directly to us. If your health plan denies payment of our claims, in whole or in part, you are responsible for paying any and all unpaid amounts within thirty (30) days of receiving our statement regardless of whether you have filed or plan to file an appeal. You hereby assign and convey directly to Kid O'Therapy, LLC all health plan benefits and/or insurance reimbursement benefits otherwise payable to us for medical services, treatments, therapies and/or examinations rendered or provided by us. You authorize Provider to release all medical information necessary to process my claims to the responsible Payor. You also agree that if any payments are sent to you despite your assignment of benefits to us, you will promptly forward the funds and explanation of benefits/payment to Provider.
- **Out-of-Network Claims.** If we are out-of-network, payment is expected in full at the time of service unless you have made other payment arrangements with us. We may, at our sole discretion, agree to set you up a payment plan or make other payment arrangements. We will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. We may agree to bill your health plan for our services directly and await payment from your health plan if you execute the assignment of benefits agreement below. You agree that if your health plan does not honor the assignment and sends payment to you, you will promptly forward the payments to us. You further agree that if your health plan denies payment of our claims, in whole or in part, you are responsible for paying any and all unpaid amounts within thirty (30) days of receiving our statement regardless of whether you have filed or plan to file an appeal.
- **Cash Payment Policy.** We offer a discounted cash payment rate when patients pay cash at the time of service in exchange for the prompt payment and the reduction in administrative work/time since we don't have to file claims or obtain pre-authorization. This cash payment discount is offered to patients who do not have insurance or who choose not to use their health plan benefits. If we are in-network with your health plan, our cash payment rate *may* be less than the in-network rate that we have negotiated with your health plan. *If you choose to take advantage of our discounted cash payment policy, you understand that we will not submit a claim to your health plan and agree that you will not submit our claims or statements to your health plan in an attempt to get reimbursed for our services.* If you choose to pay cash initially and later want to switch to using your health plan, you understand that the fees for our services may be higher and you will no longer be entitled to our discounted cash price. Your ability to switch to using your health plan benefits may also be limited by your health plan's requirements for pre-authorization or other policy limitations.
- **Workers' Compensation.** If your injury is work-related, we will bill your company's workers' compensation carrier if you have filed an injury report with your employer and your right to workers' compensation benefits is not in dispute. If you are informed that a dispute about your right to workers' compensation benefits has arisen after you have begun treatment with us, you agree to inform us immediately. You will have a choice at that time to pay for your treatment out of pocket or allow us to bill your health insurance. In the event you do not have health insurance and cannot pay privately, we will discuss your options with you at that time.
- **Auto or other Liability Insurance.** If you have been involved in a motor vehicle accident, you can choose to use your MedPay benefits (up to the limit in your policy) or your health plan benefits. If you choose to use your health plan benefits, you should know that most health plans limit coverage for therapy to a certain number of visits per year. If you use your visits for your auto injury, you may not have visits available for other therapy needs throughout the year. Therefore, you should consider using your MedPay benefits under your auto insurance policy first so you don't exhaust your health plan benefits. If you choose to use your MedPay benefits, you will pay us at the time of service and we will give you a copy of your bill that you can submit to your auto insurer for reimbursement. If you choose to bill your health plan, you will be



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responsible for all copays, coinsurance and deductibles. If your health plan limits your therapy benefits, you will also be responsible for your full bill once you reach any limitations/exclusions. If you do not have health insurance or you exhaust your health and/or MedPay benefits, we may, at our discretion, agree to await payment when your case settles. If we do, you agree to give us a lien on any settlement, judgment or insurance proceeds you receive for payment of any and all unpaid claims, including late payment interest, and authorize your attorney to pay us out of the settlement/verdict proceeds. You understand that we are not obligated to discount any portion of our service or late payment penalty fees when your case settles regardless of the amount of your settlement or whether your settlement adequately covers your balance due to us.

- **Late Payment Penalty.** A late payment penalty in the amount of 30 % on unpaid claims will be added every month that your claims go unpaid after you are discharged from our care. You agree to be personally responsible for paying such penalties unless applicable law requires your health plan or other responsible Payor to pay it.
- **Appeals.** You understand that you are responsible for filing all appeals of adverse benefit determinations. We may be willing to file appeals on your behalf if you appoint us as your Authorized Representative (see below). By appointing us as your Authorized Representative, we are given the right by you to (1) obtain information regarding the claim to the same extent as you; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit or workers' compensation plan, health care benefit plan, or plan administrator. Our acceptance of the appointment as your Authorized Representative is no guarantee that your claims will be paid or alter your ultimate responsibility to pay our claims.
- **Collection Actions.** You understand that we are not required to obtain your written authorization to disclose protected health information to a collection agency or court of law that may be necessary to collect payment for services rendered. Should collection proceedings or other legal action become necessary to collect an overdue account, you will be responsible for paying the collection costs plus court costs and filing fees incurred by the practice.

**I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.**

**CHILD'S NAME:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

X \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of Patient and/or Guardian**

X \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of Provider Representative/Witness**



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**Assignment of Benefits and Authorized Representative Appointment**

- Assignment of Benefits.** I hereby assign and convey directly to Kid O'Therapy, LLC all health plan benefits and/or insurance reimbursement benefits (including MedPay and/or Personal Injury Protection benefits), if any, otherwise payable to me for medical services, treatments, therapies and/or examinations rendered or provided by Provider regardless of its managed care network participation status. I hereby authorize Provider to release all medical information necessary to process my claims to the responsible Payor. I agree that if any payments are sent to me despite my assignment of benefits to Provider, I will promptly forward the funds and explanation of benefits/payment to Provider.
- Appointment of Authorized Representative.** By checking this box, I hereby appoint Kid O'Therapy, LLC (hereinafter "Provider") as my designated Authorized Representative to act on my behalf in the filing or pursuance of claims and appeals with my health plan, auto liability insurance plan or other liable Payor or Payors in connection with medical services, treatments, therapies and/or examinations rendered or provided by Kid O'Therapy, LLC regardless of its managed care network participation status. I understand that as a result of this authorization, the Payor(s), plan administrator, fiduciary, insurer and/or attorney may disclose and release information concerning benefit eligibility, claim status, or claim approval or denial reasons in connection with the above referenced health care claims to the Provider. Further, I hereby authorize my health plan, plan administrator, fiduciary, insurer, and/or attorney to release to Provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon request from Provider or its attorneys in order to claim such medical benefits. As my Authorized Representative, Provider is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit or workers' compensation plan, health care benefit plan, or plan administrator. Provider, as my Authorized Representative, Provider may also bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at Provider's expense. This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

**Right to Revoke Designation and/or Assignment.** I acknowledge that Provider has not made the provision of my medical care contingent upon this designation of Provider as Authorized Representative. I understand that I may revoke this Authorized Representative appointment at any time by giving written notice to Provider and Payor(s) except to the extent that any party has taken action in reliance on this appointment before they knew of the revocation. I further understand that revocation of Provider as my Authorized Representative does not release me from my obligation to pay Provider's claims. Unless revoked, this Authorized Representative appointment is valid for all administrative and judicial reviews under the Affordable Care Act, ERISA, Medicare and applicable federal and state laws until Provider's claims are paid in full.

A photocopy of this assignment is to be considered valid, the same as if it was the original.

**I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.**

X \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of Patient and/or Guardian**

X \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of Provider Representative/Authorized Representative**