the Center for Pediatric Therapy, inc.
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FINANCIAL POLICY

Effective 09/04/2020

Thank you for choosing the Center for Pediatric Therapy, inc. (**CPT**) as the therapy service provider for your child. Our staff is committed to providing the highest quality therapy services and experience for our patients and their families.

Please understand that payment of your bill is considered a part of your treatment process. As part of our service to you, we try to contain the ever-rising cost of health care. In our effort to do this, we have implemented this Financial Policy. **It is your responsibility to read and understand the content of this policy.** Please ask if you have any questions.

Completion of ALL financial intake forms, including a **SIGNED** receipt acknowledging your understanding and agreement with the terms of this policy is required **PRIOR to your first appointment.**

PAYMENT

We charge what we consider reasonable based on industry standards, the expenditure of our time, resources and expertise. "Payment due" may include any unmet deductible, co-insurance and/or co-pay amount as defined by your health insurance company, private pay for "non-covered" services and any late cancellation/no show fees.

- **CO-PAY** and **PRIVATE PAY** fees are expected at the time of service.
- **CO-INSURANCE** will be billed to you after the claims are processed by your insurance.
- Estimated **DEDUCTIBLE** may be collected at time of service. Any unmet deductible balance will be billed to you after the claims are processed by your insurance.
- **LATE CANCELLATION / NO SHOW** fees are due prior to your next appointment.
- Our **PROMPT PAY** rate is applicable for private pay services ONLY when paid at time of service.

We will accept cash, checks, debit or credit cards including Visa, MasterCard, Discover and American Express.

You have the option to pay by signing up for **EASY PAY.** An *Easy Pay Consent Form* is required for this service. The convenience of **EASY PAY** will allow us to bill your debit/credit card for any charges, co-pays or deductibles which are your responsibility but not paid at time of service.

INSURANCE

Please remember that insurance is a contract between YOU and YOUR insurance company. Ultimately, you are responsible for understanding your benefits.

You are financially responsible for costs including deductible, co-payment and/or co-insurance based on your individual plan. Any costs not covered by your insurance are your responsibility. Refer to your *Explanation of Benefits* (EOB) for specific information.

Health insurance coverage varies widely. We will assist with verification of your benefits prior to your first appointment. However, this is not a guarantee that your insurance will cover the cost of services rendered. Benefit plans are ever changing and accurate information may be difficult to obtain from your insurance company.

Even though we may participate with your insurance provider, some services may be deemed "not a covered service" under your specific insurance plan. You are financially responsible for any services considered "non-covered" by your health insurance company.

CPT is a "participating provider" with several insurance plans. We will submit all insurance claims for payment for our services with these companies. A list of these participating insurance plans is available on our website or upon request. We will accept the contracted amount for services provided.

If you do not carry insurance, or for any reason your insurance will not pay for our services, payment in full is expected at the time of your visit regardless of any insurance company's unique determination of usual and customary rates (UCR).

We will not file claims for health insurance plans we are not participating with ("non-participating" or "out-of-network"). Payment is due at time of service. Based on your "out-of-network" benefits, you may be able to file such claims directly with your insurance company. We will provide you with a superbill which contains information required to file your claim (i.e. diagnosis and treatment codes, units of service, provider information, payment made, etc.).

If your insurance company does not pay CPT within a reasonable period of time, you may be billed. CPT may elect that no "cash pay discounts" will be applied *after 30 days of our original service date to you*.

CLAIM DENIALS / APPEALS

If your claim is denied due to a billing error, CPT will make the corrections and submit the claim for reprocessing. If a claim is denied based on your benefits (i.e. "non-covered service"), you will be billed.

You have the right and option to appeal the decision made by your insurance company. You are responsible for any charges not paid by your insurance during the appeal process. If your appeal results in the denial decision being over-turned and your insurance company eventually pays the claims, CPT will refund any payments that you made for the disputed services.

Upon your request, CPT may assist you with the appeal process or file an appeal on your behalf. A fee of $28.00* per 15 minute "unit" will be charged for this service. This fee is your responsibility and will not be billed to your insurance company. If the decision is overturned, the cost for assistance with your appeal is not refundable. Although we will make every reasonable effort to support your appeal case, there is no guarantee that the appeal will result in payment of your claims.

DELINQUENT ACCOUNTS

Payment is due either at time of service and/or upon receipt of an invoice as specified above.

Accounts NOT paid within 30 days of invoicing or prior to the next billing cycle will be subject to a $10.00 LATE FEE for each additional month the balance remains unpaid.

If your account is not paid in full within 90 days of invoicing and it becomes necessary to turn your account over to a COLLECTION AGENCY, you hereby agree to be responsible for all costs of collection on unpaid balances including, but not limited to, 1.5% interest (18% annually), collection fees (up to 50%), court costs and reasonable attorney fees*.

It is our policy that when an account is 90 days overdue and/or has been referred to a collection agency, that we terminate any future therapy until the account is satisfied. This limits the amount of debt you may be accumulating.

No "discounts" of any sort will be applied to any outstanding balances or balances sent to collection. If we later receive payment from your insurer, we will refund any of your overpayments to you.

In certain situations, a **PAYMENT PLAN CONTRACT** may be required. Failure to adhere to the requirements agreed to in the Contract may result in termination of services and the account may be referred to a collection agency.

MISSED APPOINTMENTS

Cancellations require 24 hour notice. **There is a $35 fee* for a "NO SHOW / NO CALL" or "LATE CANCELLATION" with less than a 24 hour notice.** Your cancelled appointment may be a valuable appointment opportunity for another patient requiring therapy. Your child's therapist has also invested time preparing for the appointment. Please help us serve you better by keeping your scheduled appointments or providing advanced notice of cancellation. Refer to the *Cancellation and Attendance Policy* for additional details.

RETURNED CHECK CHARGE

There will be a **$35.00* service charge for CPT to process checks returned for insufficient funds**. There will likely be a bank charge as well.

CORRESPONDENCE REGARDING THERAPY OR TRANSACTION HISTORY

Completing additional insurance or medical correspondence (i.e. reports, letters, and forms), copying therapy records, etc. requires office staff time and therapist time away from patient care. We may require payment at a rate of **$20.00* per 15-minute "unit"** of time to fulfill your request. The charge will be determined by the length and complexity of your request.

PERSONAL INFORMATION

We want to assure you that we take very seriously the responsibility to safeguard any and all of our patient's medical and personal information. Therefore, we have established certain policies and procedures to ensure that your personal information will never be shared with anyone outside of this office who is not involved in your therapy or financial processes without your written consent.

With the increasing incidents of identity theft, we realize our patients may be concerned about our need to obtain your social security number, driver's license number, date of birth, and other personal information. Please do not be offended!

WHY WE MUST OBTAIN YOUR SOCIAL SECURITY NUMBER -
In essence, we are granting you **credit** by rendering services to you **before** you, or your insurance company, pays us for those services. Any merchant that grants you credit will require your social security number.

If, after reading the above information, you choose to withhold **ANY** of the information our office requires to establish your medical record and account, you will then have two choices:

1) Before services are rendered, we will need for you to complete our ***Easy Pay Consent Form*** to allow us to bill your debit/credit card for any charges, co-pays or deductibles which are your responsibility unless paid at time of service.

2) You have the option to seek care elsewhere.

PORTABILITY OF THERAPY RECORDS

In the event that you request any of your child's personal/medical record information be conveyed to another health care practitioner or educational professional, CPT will handle the situation with the utmost confidentiality. A SIGNED ***Consent To Release or Request Confidential Information*** form is necessary for us to release any information (written or verbal) to another party. As a courtesy, we will convey a copy of your child's evaluation report to one (1) provider (doctor, agency, etc.) of your choice. A **fee*** may be charged for any additional requests for conveyance of health records in accordance with the Pennsylvania ACT #26.

These fees are your direct responsibility and will not be billed to your insurance company.

I ACKNOWLEDGE BY SIGNING BELOW THAT THAT I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS POLICY.

Parent/Guarantor Signature: _____ (seal)

Date: _____

Keep a copy of this Financial Policy document for your records.

We apologize for the length and complexity of this Policy, but it is highly important that we comply with the legal terms of our insurance contracts and that our patients understand their financial responsibilities. This policy is subject to change. Any changes will be posted in the office and updated on our website. Please request a copy if needed.