OT/PT
Payment Agreement Form

By signing this document below, I acknowledge that I have read and agree to the payment and cancellation policies of the Pediatric Therapy Center of Bucks County.

I understand that all copays and private payment for services will be due at the time of service. I am permitted to prepay copays for multiple visits if I desire.

Cash, checks and credit cards (VISA, Mastercard, Discover) are accepted. Flexible Benefit cards carrying one of these logos are also accepted.

If my insurance is being billed for services, my signature on this form acts as my authorization to release any medical or other information necessary to process the claim. I will be expected to pay my copay at the time of the visit. I further authorize payment of medical benefits to the Pediatric Therapy Center of Bucks County, LLC for services provided. If the insurance company denies covering these services, I understand that I will be responsible for paying them. PTCBC in no way guarantees that my insurance company will choose to approve payment for my child's services.

If I am paying privately for therapy services, and am receiving the private pay discounted rate, I understand that bills for these services will not be submitted to my insurance company and no documentation regarding these services will be supplied to me or my insurance company in support of payment for these services.

I understand that the **cancellation policy** is as follows:

> The staff at the Pediatric Therapy Center of Bucks County recognize that children become ill. We also realize that children have the potential to pass that illness to others. We require that children be fever-, diarrhea-, and vomiting-free for 24 hours before returning to our clinic for care. In the interest of providing parents with the flexibility to keep an ill child at home and to limit potential cross-infection, each client will be granted 2 illness cancellations per calendar year without being charged a cancellation fee.
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> For all other cancellations with less than 24 hours notice a fee of $25.00 will be charged and will be due at the next appointment along with the fee for that appointment. "No show" appointments will incur a charge of $50.00 and will be due at the next appointment along with the fee for that appointment. This fee will be waived if the cancelled appointment is rescheduled into an available appointment slot within the same calendar week, and the child attends the rescheduled session.

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After any combination of 3 “No shows” and/or “late” cancellations within six months, PTCBC retains the right to remove the client from a recurring appointment spot or discharge the client. A patient removed from a recurring spot will have the opportunity to schedule upcoming appointments on a week-by-week basis based on availability.

A “late” cancellation is considered less than 24 hours notice.

If you are more than 15 minutes late for your child’s scheduled session, we also consider this a “late cancellation.” Your child may be able to be seen for a partial session at the therapists’ discretion, but a “cancellation” fee will still apply in addition to any copay.

Research shows that children whose families are committed to therapy and who attend as prescribed have the most successful outcomes.

Additional consultation fees: As a service to our families, 30 minutes of outside consultation time will be provided for free to consult with other professionals treating the client (with written parent approval). These would typically be therapists treating the client in another setting, a psychology professional working with the client etc. If you feel you will require extensive consultation from one of our staff members, please ask for our rates.

Legal consultation fees: Any staff consultation regarding legal issues is ALWAYS billable whether it be with the client, family, lawyer, advocate, etc. If you are in need of these services, please request our current rates.

Medicaid Waiver of “cancellation/no show” fees:

I understand that by signing the agreement below, if my child has a Medicaid plan, I also waive my right not to be assessed cancellation and no show fees in the situations outlined above in this agreement.

Child’s Name:_____

Child’s Name:_____

_____ _____ _____

Printed Name (Parent) Signature Date