Pediatric Physical & Occupational Therapy Services - *Seattle, WA*

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

Contract for Services

I understand that Pediatric PT & OT Services does not verify insurance eligibility and benefits. I am responsible to confirm that Pediatric PT & OT Services is a contracted provider with my specific insurance plan and to verify OT benefits, visit limitations and all plan requirements for Occupational Therapy services.

I understand I am responsible to obtain a physician referral and insurance authorization whenever necessary. I will notify Pediatric PT & OT Services if prior-authorization must be obtained by Pediatric PT & OT Services. I will confirm all necessary documents are on file with insurance and Pediatric PT & OT prior to the first OT appointment. I am responsible for payment of any incurred charges denied by insurance because a mandatory physician referral and/or prior-authorization were not obtained.

I agree to keep track of insurance plan limitations on number of OT visits allowed per benefit year and authorizations, i.e, the number of visits used relative to those authorized and the expiration date of authorizations. To allow time for submission and review of paperwork and to help avoid a break in services while records are reviewed; I will notify my therapist (or the office) at least one month before the approved number of visits are used and/or one month prior to the authorization expiration date. I am aware that my insurance company may request information to establish medical necessity regarding my child's treatment from *Pediatric PT & OT Services and I give my consent for the release of this information.*

I understand that I am responsible for payment of my account and to guarantee that the account is paid on a timely basis – whether payments are made by me or my insurance company. If claims are submitted to insurance and payment is not received within 45 days I agree to follow up with insurance regarding payment and to continue to make regular monthly payments if insurance payment is delayed or denied.

As part of ongoing therapy services the initial 4 observation sessions are billed at $150 per hour and regular treatment sessions are billed at $135 per hour. Pediatric PT & OT will submit claims to insurance. A 10% cash discount is available on the hourly treatment rate – not for the initial 4 observation sessions.

Cancellation Policy

I understand that with the exception of illness or emergency, I am required to notify the practice a minimum of 72-hours prior to any cancelled or missed appointments. If I do not provide 72 hour notice, then I will be charged for any missed or cancelled appointments. The cancellation fee is ½ of my hourly rate and the charge cannot be submitted to my insurance.

I have read, understand and accept the terms of the above Contract for Services and Cancellation Policy

Parent/Guardian/Signature_____

Date

Insurance waiver – Non Medicaid Contracted Provider

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

I understand that my insurance company may *not* consider the Occupational Therapy services provided by Pediatric PT & OT to be a covered medical expense. 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 *Pediatric PT & OT* provide Occupational Therapy services for my child. I understand that if my insurance company does not allow benefits or approve payment of claims for services my child has received, *I am responsible for all incurred charges and I agree to pay the balance in full in a timely manner*.

I understand that Pediatric PT & OT Services is not contracted with Department of Social and Health services to accept Medicaid benefits. I understand that all services provided by Pediatric PT & OT Services are not covered by DSHS medical assistance programs and are not included as part of another service. I choose to receive services from Pediatric PT & OT Services and agree to pay for the services. Therefore, if my child is covered by DSHS Medical Coupons or any Apple/ Medicaid Plans, I understand that alternate funding is necessary for any services received from Pediatric PT & OT Services.

I have read, understand and accept all of the terms shown above in the Insurance Waiver.

Parent/Guardian Signature_____

Date