DARLING PEDIATRIC THERAPIES, INC.

1475 Holcomb Bridge Rd., Suite #113, Roswell, GA 30076

678-591-3542 Fax: 770-234-6837 Email: DarlingOT@msn.com

WWW.DarlingPediatricTherapies.com

FINANCIAL AGREEMENT – PATIENT GUARANTEE of PAYMENT/ HIPAA/ Disclosure of Information

Darlene A. Robertson, OTR/L, Darling Pediatric Therapies and its agents hereafter referred to as **TSP** (Therapy Service Provider) agrees to provide therapeutic services, including but not limited to, Occupational Therapy, Physical Therapy, Speech Therapy or any therapeutic services offered by TSP, at the scheduled appointment times as agreed upon by and between TSP and the Patient, Patient's Guardian or other authorized Legal Patient Representative.

Patient Name: ____

The Patient, or Patient's Guardian or authorized Legal Patient Representative, agrees that in consideration for the therapeutic services provided by and completed by TSP, at the scheduled appointment time, they will be held fully responsible for payment as listed below:

Cash Patients:

Therapy Services: ***Regular Rate***: $200 per 1 hour Session –
(a 32% discount ("*Regular Rate*" reduced by $65.00) will be given for any payment received within 30 days of the "date of service" for any therapy services rendered.)

Patient Evaluation: ***Regular Rate***: $350 per Evaluation –
(a 20% discount ("*Regular Rate*" reduced by $75.00) will be given for any payment received within 30 days of the "date of service" for any evaluation performed.)

Travel Expenses: A rate of $20 per home visit, will be added to any home therapy session visit. This is for travel and time.

Private Insurance Patients:

TSP is a "Preferred Provider" of therapy services for specific private insurance carriers (e.g. Blue Cross/Blue Shield, Humana, Tricare etc.) and other governmental programs. If a Patient falls into this category, TSP will accept the contracted services payment as agreed between the Private Insurance Carrier/Governmental Program and TSP, as payment. Patient will be responsible for any deductibles, copays or other fees determined by the insurance carrier.

If TSP is "out of network" with a specific private insurance carrier, the Regular Rate will be billed and collected in full. Patient is responsible for therapy service fees.

Medicaid Patients;

TSP will bill your private insurance providers first. Then, Medicaid will be billed for the subsequent remainder as provided by Medicaid guidelines. TSP will accept the Medicaid reimbursement as payment in full. If Patient is denied Medicaid reimbursement for any reason, TSP will file and appeal if applicable. Should, on appeal, the Patient be denied reimbursement from Medicaid, the Patient is responsible for the payment for services rendered at the "Cash Patient" discounted rate. **The Affordable Care Act (ACA) which requires all physicians or other eligible practitioners who prescribe or order services for Medicaid recipients, or who refer Medicaid recipients to other providers, to be enrolled as a Medicaid provider.**

IMPORTANT NOTICE:

CHANGE OF INSURANCE INFORMATION

Patient must present his/her Private Insurance Provider card and information prior to any treatment. Should the patient switch their medical insurance coverage, carrier or status during the time of treatment, it is required for the patient to notify **TSP** immediately (prior to treatment). Failure of the patient to immediately notify **TSP**. of any insurance changes will make the patient fully liable for the full amounts billed for the services, which is due immediately upon request from **TSP.** Should **TSP** have received insurance reimbursement improperly because of insurance changes and information was not received, **TSP** is required to return the improper disbursement back to the insurance carrier. ***The patient is responsible for complete and immediate reimbursement for the full amount of returned funds and any bank fees or postage fees.*** This amount is to be paid directly to **TSP** upon request.

USE AND DISCLOSURE OF PATIENT INFORMATION

Your medical information will be used for payment and operations to maintain the highest quality care possible. HIPPA allows disclosure of this information to your designated/ authorized next of kin and other health providers, including physicians, insurance companies' state and federal entities as well as law enforcement agencies in the interest of public safety. You, the patient/ guardian, however, reserve the right to request in writing, restrictions on certain uses and disclosures.

In addition to the above entities, TSP, may communicate with the following persons on my behalf for my course of treatment and my health condition: (i.e.: physicians, neurologist, developmental pediatrician, school therapists, and teachers)
Please list persons you give TSP authorization to contact and their contact information:

____

____

____

All information exchanged will remain confidential. The participant or guardian has the right to revoke this release at any time in writing, but not retroactive to the release of information made in good faith at the date indicated below or prior to the date consent is revoked.

CONSENT FOR EMAIL COMMUNICATION

Electronic mail (e-mail) can be a useful tool in the practice of therapy and can facilitate communication within a patient/parent-therapist relationship. There is a risk regarding potential breaches of privacy and confidentiality, difficulties in validating the identity of the parties, and delays in responses. Patients should have the opportunity to accept these limitations prior to the communication of privileged information. **Should you accept email communication regarding treatment, invoices and payment (via our PayPal account) please supply your email below:**

____

This form has been fully explained to me and I hereby acknowledge, accept and certify this by signing this Agreement. Further, I authorize the release of the Patient's requested Medical Records to my insurance company, Medicaid, Governmental Programs and other Health Insurance Portability and Accountability Act (HIPPA) compliant companies necessary to obtain payment for services rendered to my child. I authorize the disclosure of patient information to the individuals I have listed above. I have been offered a copy of the HIPAA notice and know its location on the website of TSP.

I, ____

(Please **Print Name** of Patient Guardian, Patient or Patient Legal Representative)

____

(Patient, Patient Guardian, Patient Legal Representative **Signature**)

do hereby authorize TSP to invoice for, and receive payment from Patient's Insurance Provider, for therapy services rendered to Patient.

Date: ______________________

Witness: ____

(Please **Print Name** of Witness)

____

(Witness **Signature**)