FINANCIAL POLICY STATEMENT

Thank you for choosing us as your health care provider. We are committed to you or your child's treatment being successful. Please understand that payment of your bill is considered part of the treatment. The following is a statement of our financial policy that we require you to read and sign prior to any treatment.

By your signature below, you indicate that you understand that you are ultimately responsible for payment of your bill. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is your responsibility to know your benefits. We accept assignment of benefits on verified insurance policies and as a courtesy bill your insurance carrier. Co-pays, co-insurance and deductibles are due at the time of service. Any remaining unpaid balances after the insurance company(s) have paid, that are based on the contract rate between Abilitations Children's Therapy & Wellness Center, LLC (ACTWC) and the insurance carrier, are due within 60 days**.** If your insurance carrier has not paid your account within 60 days (of bill submission), the balance will be due in full from you.

In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you for the services billed by us, you recognize an obligation to promptly remit same to ACTWC. You understand and agree that if you fail to make any of the payments for which you are responsible within 60 days, you will be responsible for all costs of collecting monies owed.

Regarding your insurance benefits: ACTWC has verified your benefits for you before your initial appointment. This verification includes, but does not guarantee, the following: your co-pay, co-insurance, any deductibles that may apply, the number of visits allowed on your plan and whether or not your plan requires referral or authorization from your primary care physician. It is in your best interest to call your insurance company as well to verify the above stated terms of your benefit plan. Your insurance company, not ACTWC, will determine if these charges will be covered when they receive an insurance claim from us which includes the procedure that took place and the diagnosis.

ACTWC provides the service of filing your insurance claims. However, if a payment has not been received from your insurance carrier within 60 days, or if they ask for medical records or any other type of delay, you will be asked to begin paying in full for future services rendered. If the insurance company begins to pay on the account, we will promptly refund the dates of service you have paid.

Usual and customary rates: Our practice is committed to providing the best services for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Changes in your insurance coverage: It is your responsibility to inform this office of any and all changes of insurance coverage during course of treatment. It is your responsibility to inform us that your insurance coverage is about to change so that we can verify your benefit and obtain prior authorization as required. Failure to provide this information will result in the patient (guardian) being responsible for payment of all non-covered and/or unauthorized services. In the event of non-notification of insurance changes in which ACTWC incurs extra fees for "rebilling" will result in the patient being responsible for those charges.

Appeals Process: In the event that you exhaust your benefits or your insurance denies claims with ACTWC, the insurance company often requests an Appeals Process. The Appeals Process is between you and your insurance company and not ACTWC. However, we can assist in providing you with reports to include evaluations and progress reports to submit to your insurance company. You will be responsible for gathering the requested information, sending to your insurance company and following up with them concerning their response to your request.
During the Appeals Process ACTWC is not receiving payment from your insurance company. This in turn will result in you paying in full for the treatment sessions your child receives. If you cannot pay in full for the treatment sessions you will need to place treatment on hold until the appeals process is complete. Unfortunately if you choose to place sessions on hold we cannot guarantee your time slot will be held but we will work with you to make this process easier.

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITIES FOR THE PAYMENT OF MY ACCOUNT.

Patient Name	Patient/Guardian/Responsible Party	Date

CONSENT FOR CARE AND TREATMENT

By my signature below, I do hereby agree and give my consent for Abilitations Children's Therapy & Wellness Center, LLC to furnish medical care and treatment to ___________________________________considered necessary and proper in diagnosing or treating his/her physical condition.

_______________________________________ ________________________

Patient/Guardian Date

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicaid, private insurance and third party payers to Abilitations Children's Therapy & Wellness Center, LLC. A photocopy of this assignment is to be considered as valid as the original. I further authorize the release of all pertinent information to a third party, including Medical Records, as may be necessary for billing and collection purposes.

_______________________________________ ________________________

Patient/Guardian Date

INFORMATION PRIVACY STATEMENT (HIPAA)

Abilitations Children's Therapy & Wellness Center, LLC will use and disclose you(r) child's personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. By signing below, I acknowledge receipt and review of Abilitations Children's Therapy & Wellness Center's Notice of Privacy Practices.

_______________________________________ ________________________

Patient/Guardian Date

POLICIES AND PROCEDURES

I have received and familiarized myself with Abilitations Children's Therapy & Wellness Center's Policies and Procedures and agree to the statements regarding our treatment session times, cancellation and no show policy, infection control procedures, inclement weather policy, and patient rights and responsibilities.

_______________________________________ ________________________

Signature Date

11030-101 Raven Ridge Road, Raleigh, NC 27614 Phone: 919-844-6611 Fax: 919-844-6612