Financial Policies

Thank you for choosing Jump Start Pediatric Therapy for your child's therapy services! We are committed to making your therapy experience successful, so we want you to be informed of our financial policies and your financial obligations. **You are ultimately responsible for the full payment of your account.** We offer the following information to make this responsibility as manageable as possible.

YOUR BENEFITS: Your insurance policy is a contract between you and your insurance company. We urge you to review your insurance benefits and to contact your insurance company with questions. The contact information for your insurance policy is located on the back of your insurance card. Your child will be receiving outpatient physical therapy, occupational therapy, and/or speech therapy in the office or telehealth setting. Your child's age could affect eligibility for some benefits. Benefits for in-network and out-of-network services often differ. We will verify your insurance eligibility and benefits, but we cannot guarantee the accuracy of the information we receive. You are ultimately responsible for knowing your insurance benefits and for the full payment of your bill.

YOUR RESPONSIBILITY: You are responsible for co-payment, coinsurance, and/or deductible as specified in by your insurance policy. You are responsible for the cost of any service provided that is not covered under your policy. If you have a deductible that has not been met, we will collect 100% of the visit charge at the time of service until the deductible is met. If you have coinsurance, we will estimate and collect your share of the cost at the time of service. These payments will be applied toward your account balance and reviewed as claims are processed by your insurance company. Any additional patient responsibility will be billed after insurance claims process.

DATE OF SERVICE DISCOUNT: A discount will be applied to a patient account if the following two conditions are met:

1) Your child does not have a medical insurance plan that includes a benefit for the outpatient therapy service(s) he/she receives.
2) Your full payment for services rendered is received on the date of service**. If payment is not received on the date of service, the discount is no longer valid, and the <u>full price</u> of the services will be charged**

CHANGES IN COVERAGE: It is your responsibility to inform us of any change in your insurance coverage at the time of service. You will be responsible for charges incurred if delayed notification results in delayed billing or denied payment. In some cases, this may result in a financial suspension of therapy services until the account is paid.

INSURANCE BILLING: As a courtesy, we will submit claims to your insurance company on your behalf. If your insurance requires a referral or prior authorization for therapy services, it is your responsibility to verify we have received the required document before your scheduled service. If your insurance does not accurately or completely process a claim within 60 days, you will be responsible for all outstanding charges. If your insurance company requests a refund of payment previously made, you will be responsible for the amount Jump Start Pediatric Therapy refunds to your insurance company. If any payment is made directly to you for services billed by Jump Start Pediatric Therapy, you are obligated to promptly submit the same amount to Jump Start Pediatric Therapy.

PATIENT STATEMENTS: A billing statement will be generated each month you have a balance due. You are responsible for providing us with a current email or physical mailing address. Your full balance

is due upon receipt. If you are unable to pay your full balance, please contact us immediately to discuss payment arrangements and continuation of service.

FINANCIAL SUSPENSION & DISCONTINUATION OF SERVICE: Therapy services will be suspended for any patient with an account balance over 60 days past due. Appointment times will not be reserved during a financial suspension. Services may be resumed if the account balance is paid in full before it becomes 90 days past due. Therapy services will be discontinued for any patient with an account balance over 90 days past due.

COLLECTIONS: If you inform us of inability to pay your account balance before it is 60 days past due, we will work with you to develop a payment agreement and avoid sending your account to collections. If any balance on your account becomes 90 days past due, we will send this balance to our collection agency.

DISPUTES: Your insurance policy is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding your policy.

PAYMENTS DUE AT THE TIME OF SERVICE:

1. Co-pays required by your insurance policy.
2. Estimated co-insurance.
3. Full payment (100% of visit charge) for any service if insurance deductible is not met.
4. Full payment (100% of visit charge) for any service not billed to an insurance plan. A Date of Service Discount will be applied to the patient account if the criteria are met.
5. Full payment (100% of visit charge) for any elective service not covered by your insurance plan.

Payments are accepted in our office, via text-to-pay, and through our Fusion patient portal. We accept cash, check, and most bank cards. There will be a $25.00 service charge for all returned checks. A $10 minimum is required for credit card payments.

PLEASE NOTE: The amount collected at the time of service may NOT be your total balance due. Your responsibility or any remaining portion thereof, as indicated by your insurance company, will be billed to you as claims process.

Financial Form

INSURANCE INFORMATION

Primary Insurance Company ____

Secondary Insurance Company ____

COURTESY INSURANCE BENEFIT VERIFICATION

Insurance eligibility and estimated insurance benefit information is provided as a courtesy to our patients, but it is not intended to release you from total responsibility for your account balance. This is only an **estimate** of the amount due from you**.** The attached summary of your current insurance benefits was verified on _________________ by ______________________________.

ACCOUNT GUARANTOR (person(s) financially responsible for patient account)

Guarantor Full Name _____________________________________ DOB: ___________________

Social Security Number ________-_____-________ Primary Phone (______)___________________

Street Address (no PO Box) _______________________________________ Apt/Suite _________

City ____ State __________ Zip ______________

Employer _______________________________ Employer's Phone (___ ___}_________________

ASSIGNMENT OF INSURANCE BENEFITS

As the account guarantor, I assign to Jump Start Pediatric Therapy all insurance benefits held on the patient's behalf for therapy services rendered by Jump Start Pediatric Therapy. I understand that Jump Start Pediatric Therapy has the right to refuse or accept assignment of such benefits. If these benefits are not assigned directly to Jump Start Pediatric Therapy, I agree to forward to Jump Start Pediatric Therapy all health insurance benefits and other third-party payments that I receive for services rendered by Jump Start Pediatric Therapy immediately upon receipt.

__________ Parent/Guardian Initial

RECIEPT AND ACKNOWEDGEMENT OF FINANCIAL POLICIES

I have read Jump Start Pediatric Therapy's Financial Policies, and I agree to the conditions stated. **I understand and accept my responsibility for the timely payment of my account.**

__________ Parent/Guardian Initial

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Printed Name of Patient — Patient Date of Birth

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Printed Name of Account Guarantor

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Signature of Account Guarantor — Initials — Date