maple valley pediatric therapy

Patient/Guarantor Insurance Information and Financial Policy

Child's Name:_____ Date of Birth: _____ Gender: ☐ male ☐ female

_____

Primary residence *City* *State* *Zip*

Primary Physician: _____ Clinic Name: _____

Diagnosis(es) or Reason for Treatment: _____

Primary insurance:_____ Subscriber ID: _____ Group Number: _____

Guarantor: _____ Date of Birth: _____ Gender: ☐ male ☐ female

_____

Address- if different than child *City* *State* *Zip*

Phone: _____ Relationship to child: _____

Secondary insurance:_____ Subscriber ID: _____ Group Number: _____

Guarantor: _____ Date of Birth: _____ Gender: ☐ male ☐ female

_____

Address- if different than child *City* *State* *Zip*

Phone: _____ Relationship to child: _____

Financial Policy: Please Read, Initial Each Item and Sign Below

As the parent/guardian and financially responsible party for above patient receiving services at Maple Valley Pediatric Therapy, *A Division of Relaxing Resources*, and PLLC *(hereafter referred to as MVPT),*

Please Initial: **I, _____ understand and agree to each of the following:**

_____ I understand that it is my responsibility to verify OT benefits with my insurance company and provide the information to MVPT. This includes copay amounts, pre-authorizations, visit limits, etc.

_____ I give my permission for MVPT to also verify information with my insurance as a courtesy but results obtained are not a guarantee of benefits. *I understand that I am ultimately responsible for payment of all services received regardless of insurance coverage.*

_____ I understand that visits may be limited by my insurance and/or shared with other therapies. I am responsible for keeping track of the number of visits my child has received and will notify MVPT when my limit has been reached.

_____ I authorize MVPT to release to my insurance company any and all information necessary to process any claim.

_____ I authorize that insurance payments be made directly to Maple Valley Pediatric Therapy, A Division of Relaxing Resources, PLLC.

_____ Copayments /deductibles are due at the time of service. A $25 fee will be charged for checks returned for non-sufficient funds or if a credit card on file is declined.

_____ If my insurance denies a claim(s), I have the right to appeal their decision. *I will be responsible for all payments for services denied by insurance for treatment already provided and ongoing treatment (if continued), until the insurance appeal has reversed the denial and insurance payment has been made to MVPT.*

_____ Appointments must be canceled *at least 24 hours in advance or a $50 fee* will be charged. *Missed appointments cannot be billed to insurance and are the responsibility of the patient/parent.*

Signature: _____ **Date:** _____