wild & free
PEDIATRIC THERAPY

FINANCIAL AGREEMENT

Services may be covered in full or in part by your health insurance. Please verify your coverage carefully by contacting your insurance provider prior to your first appointment. Your insurance company can explain your benefits, including any copay, deductible or limits on sessions. By signing this form, clients agree to allow Wild and Free Pediatric Therapy PLLC to release information to their insurance provider for processing claims. Clients are responsible to pay any portion of fees not covered by their insurance carrier.

Payment

Patients are responsible for all copays and coinsurances, in addition to fees for missed appointments. Patients with a balance due may be removed from schedule until remediated with no guarantee of hold on appointment time. A credit card may be held on file for payments. The card number is encrypted and held by a secure payment program. By signing this form, I agree that this card on file will be charged for the agreed upon fee for service unless alternate payment is arranged. Clients have the option of making payment in another form. Payments accepted include cash, check made out to Wild and Free Pediatric Therapy, and credit cards.

Patients are responsible for missed appointments and must give a one working day, 24 hours notice of cancellation. If appointments are cancelled with less than 24 hour notice there is a $25 cancellation fee. Patients with less than 75% attendance to scheduled appointments or with >3 no-shows will be removed from standing appointment spots.

Fee for Service

Some clients may choose to not use insurance benefits to cover or offset the expense of therapy. You can request a statement or “superbill” if you prefer to file on your own at a later time.

Your signature on this document indicates you understand and agree with the financial policies as outlined here.

Patient Name_____

Parent/Guardian Name _____

Parent/Guardian Signature _____

Date:_____ Witness:_____