Therapy Solutions for Kids

5200 SW Macadam Ave. Suite 100 Portland, OR 97239 Telephone: 503 224-1998 Fax: 503-224-5176

PAYMENT POLICY

This is a statement of Therapy Solutions For Kids, LLC office policies. Please read and if you have questions please discuss with our office manager or one of the owners.

Cancellations and Missed appointments policy

Cancellations must be made the day before the next appointment. Allowance will be made for sudden illness, but notice of cancellation is still required. **Missed** appointments will be billed to you @ $75 per appointment. Please note that missed appointments cannot be billed to insurance.

Primary/Secondary Insurance Billing

As a courtesy, we will bill most insurance carriers directly. You will be billed for any co-insurance/deductible monthly. It is your responsibility to provide correct information for billing your insurance. A copy of your current insurance card is required at your first visit. It is your responsibility to notify this clinic immediately if your insurance coverage changes. Patients are requested to determine benefits prior to their appointment. Co-payments **must** be paid at the time of service. TSFK will be happy to assist you with this. A $10.00 handling fee will be added for co-pays not received at the time of service.

Outstanding accounts

When an account is 90 days overdue we cannot continue to provide additional services until a payment plan has been arranged with our billing office. A billing fee of $10 may be added to balances over 90 days overdue for each month they remain unpaid. Checks returned for non-sufficient funds (NSF), closed accounts or other problems are subject to a $30 service fee and any other charges incurred by the TSFK.
Accounts subject to collection activity may be charged a 32% collection fee.

Non Covered Services

If I choose to obtain the services listed below and they are not covered by my insurance, I agree to be financially responsible for any and all related charges. *Parents/guardians are responsible for all charges resulting from treatment provided by TSFK.*

Initial

____I have read and been asked if I want a copy of the Payment Policy for Therapy Solutions for Kids, LLC.
____My signature below indicates that I understand this policy and that I agree to pay amounts due for services received.
____I have been asked if I wish to receive a copy of the Privacy Practices.
____I authorize Therapy Solutions For Kids to release information necessary to process my insurance claim to the insurance company.
____I also authorize payment to be made directly to Therapy Solutions For Kids.
____I also understand that if insurance denies charges made will be my responsibility.

My signature below also authorizes treatment for my child. This policy does not expire until my insurance changes or I am discharged.

Services provided for: ____________________________________
(Patient's Name)

Member's Signature: ____________________________________

Name of Insurance: ____________________________________

Date: ____________________________________

Services being rendered: **__OT __PT __ST __Other**

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