Bartlesville Hope
Pediatric Therapy

PRIVATE INSURANCE UPDATES/CHANGES/ADDITIONS/DELETIONS

You are responsible for informing **Bartlesville Hope Pediatric Therapy** and **OHCA** of ANY insurance changes or updates. If lack of information is provided to **Bartlesville Hope Pediatric Therapy** results in denial of claims, you will be financially responsible for all visits denied for non-payment.

I have had an opportunity to read and understand the Financial and Health Insurance Policy Statement of Bartlesville Hope Pediatric Therapy and am agreeable to all the policies stated. I understand my responsibility for full and prompt payment on my/ my child's account.

Signature:_____ Date:_____

Patient Name:_____ DOB_____PT/OT/SLP

Relationship to Patient:_____

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www.bartlesvillehopepediatrictherapy.com