Bartlesville Hope
Pediatric Therapy

Bartlesville Hope Pediatric Therapy
117 W. 5th St.
Bartlesville, OK 74003
Phone: 918-203-3313
Fax: 918-512-4082

CONSENT FOR TREATMENT FOR:
BARTLESVILLE HOPE PEDIATRIC THERAPY

Patient Full Name:_____
Date of Birth:_____

I, the undersigned, do herby authorize and give my consent for ***Bartlesville Hope Pediatric Therapy*** to provide Occupational, Physical, and/or Speech Therapy services including patient evaluations and therapy sessions as recommended by Bartlesville Hope Pediatric Therapy.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all medical benefits/payments which I/my child am/is entitled, including Medicaid, private insurance and third party payers to ***Bartlesville Hope Pediatric Therapy*** for services rendered. I hereby authorize ***Bartlesville Hope Pediatric Therapy*** to release all information to my insurance company, per their request, necessary for processing insurance claims. I authorize provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf. Please note that benefits provided prior to treatment are only an estimation and not a guarantee of payment. Benefit are determine at the time claims are processed and are subject to change. It is the parent/guardian of the patient responsibility to determine if the estimation of benefits is correct. Bartlesville Hope Pediatric Therapy encourages the patient to call the insurance company to determine correct benefits.

CANCELLATION AND NO-SHOW POLICY

We understand there may be times when you are unable to keep your appointments, but we ask the courtesy of a phone call or text to cancel your appointment. **If you do not give a two hour notice** of your cancellations, you will be charged a **$25 fee**. If a family has 2 failed visits, they will be notified that they have one remaining visit left prior to discharge. This will be documented by the treating therapist and administrator. The 3rd failed visit will result in discharge from therapy services and notification will be sent to the primary care physician regarding the discharge from service. Cancellations due to fever, illness, diarrhea, are necessary to protect the health of our other patients. Please know every effort will be made to make up that visit given prior notification is provided to therapist. There is a zero tolerance policy for bringing your child to therapy within 24 hours of running a fever of 99.9 or having diarrhea due to our medically fragile children and we reserve the right to send your child and

you home. Each patient must be fever free and diarrhea free for 24 hours before returning to therapy.

FINANCIAL AND HEALTH INSURANCE POLICY

Bartlesville Hope Pediatric Therapy appreciates you selecting us to meet your child's therapy needs. These services imply a financial responsibility on your part. ***Bartlesville Hope Pediatric Therapy*** will verify your coverage/benefits and bill your insurance carrier on your behalf. However it is ultimately your responsibility for payment of co-pays at time of service and payment for all of services received.

You are also responsible for payment of deductibles and/or co-insurance at time of visit. We will bill your insurance carrier soley as a courtesy to you. We will submit claims to your insurance provider and assist you in any way we reasonably can to help get your claims paid. Please be aware that the balance of your claim is your responsibility regardless if your insurance company pays. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

We accept payments by cash, HSA cards, FSA cards, Visa, Mastercard, and debit cards bearing these logos. Payment is expected at time of service. If your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same to ***Bartlesville Hope Pediatric Therapy***. IF you pay by check you expressly authorize to electronically debit your account in the amount of the check plus a processing fee up to the state maximum legal limit. IF your check is dishonored or returned for any reason there will be a $45 dollar processing fee added to your balance due.

I Understand and agree that if I fail to make any payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

A discount will be provided if you do not have insurance coverage. ***Bartlesville Hope Pediatric Therapy*** understands special needs. If special arrangements are needed,

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please contact us at 918-203-3313 to discuss the matter with our billing department as soon as possible so specific arrangements may be agreed upon. If you have any questions, please feel free to ask. We are dedicated to you and your child receiving the therapy they need.

I _____ (print) 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 account.*

Signature:_____
Date:_____
Relationship to the Patient:_____
OFFICE REPRESENTATIVE_____
Witness Date:_____