Pediatric Therapy Services
304 NE Hood Ave Gresham, OR 97030
Phone: 503-666-1333
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Patient Contract for Services

Acceptance of Services- I understand that by signing this agreement, I authorize provision of products and/or services to me by Pediatric Therapy Services. I also understand that the products and services provided are prescribed by my attending physician during the course of my care.

Medical Information Authorization- I hereby authorize release to Pediatric Therapy Services any and all of my child's medical records pertaining to my child's medical history, services rendered, or treatments received from my physician(s), hospital or nursing agencies. In order to process insurance claims, I also hereby authorize Pediatric Therapy Services to furnish to my insurance carrier(s), any medical history, services rendered, or treatment needed. I also understand that my information may be subject to review by credentialing accreditation or Governmental agencies.

Insurance Waiver- I understand that my insurance company may not consider the Occupational, Speech Language Pathology, or Physical Therapy services provided by Pediatric Therapy Services to be a covered medical expense. I understand that even when Occupational, Speech Language Pathology, or Physical Therapy services are listed as being a covered medical expense on my insurance plan, payment is not guaranteed. Upon receipt of claims for services rendered, my insurance company may complete a review for medical necessity and based on that review (related specifically to my child) the services may not be considered to be medically necessary or may be considered as non-covered expenses and may not paid by my insurance company. I elect to have Pediatric Therapy Services provide Occupational, Speech Language Pathology, and/or Physical Therapy services for my child. I understand that if my insurance company does not allow benefits or approve payment of claims for services my child has received, I am responsible for all incurred charges and I agree to pay the balance in full.

Assignment of Benefits- I hereby authorize payment from my insurance company directly to Pediatric Therapy Services for services provided. In the event that my insurance carrier does not accept "assignment of benefits", I understand that payment may be sent directly to me and that I am obligated to endorse and directly send payments to Pediatric Therapy Services for payment on my account.

Authorizations for Services- I understand that I am responsible to obtain a physician prescription for all services and my insurance company may also require a referral and/or insurance authorization. I understand that it is my responsibility to keep track of the number of visits used relative to those authorized, the expiration date of any authorization and/or the contract limitations of my insurance plan. If progress reports and/or treatment plans are required by my physician or insurance company, I will notify my therapist at least one month before they are due, to allow time for completion of the paperwork. I understand that I am obligated to report any changes in insurance coverage promptly to Pediatric Therapy Services.

Financial Responsibility- I understand that I am responsible for payment of my account on a timely basis, whether payments are made by me or by my insurance company. Insurance co-pays are due at the time of service. If claims are submitted to insurance and payment is not received within 45 days, I agree to follow up with the insurance company regarding payment and personally make regular payments on my account. All charges are due in full within 60 days from date of service unless a separate payment arrangement has been approved and signed by both Pediatric Therapy Services and myself. In the event that my insurance company denies payment, I am fully and directly responsible for the payment of all charges. My portion of the bill is due upon receipt of the statement. Any unpaid patient balances over 60 days will be charged 1% interest (18% annually). Patient balances unpaid over 90 days will be sent to collections.

Medicaid Clients- I understand that if I have Medicaid I am not financially responsible for covered items as long as my Medicaid number is active at the time of delivery. I further understand that I may/will be responsible for charges if my Medicaid status changes. I will promptly notify Pediatric Therapy Services of any changes in Medicaid coverage or plan type.

My signature below indicates that I have read and understand all items listed in this patient contract for services.

_____ _____

Signature Date

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Relationship to Patient