Advanced Therapy Solutions

FINANCIAL AGREEMENT

Carefully review the policies outlined below. Initial on the line to acknowledge that you fully understand the agreement.

We would like to thank you for choosing **Advanced Therapy Solutions, LLC** and for allowing us to provide your family's healthcare needs. The policies listed herein have been carefully reviewed with the goal of providing you and your child the finest care and service at the least cost.

Care delivered by Advanced Therapy Solutions, LLC will be administered regardless of race, color, creed, social status, national origin, handicap or sex.

The staff at Advanced Therapy Solutions, LLC are committed to providing you with the best possible care. In order to accomplish this, Advanced Therapy Solutions, LLC can assistance you in reading and understanding financial responsibility and our payment policy.

_____ Responsibility for the Bill:
It is the expectation that all patients/guarantors receiving services are financially responsible for the timely payment of all charges incurred. The clinic will submit to participating insurance companies for payment of the bill(s) as a courtesy to the patient. The patient/guarantor is ultimately responsible for payment and agrees to pay the account in accordance with the established rates per our current fee schedule and terms of the clinic in effect at the present time.

Balances after insurance reimbursement are due within 30 days of the insurance payment, unless other satisfactory arrangements have been made with the clinic.

Not all services are covered by all insurance companies. It should be understood that by accepting the service(s), the patient is responsible for payment regardless of the fact that insurance covers the service or not.

_____ Outstanding Bills:
Advanced Therapy Solutions, LLC reserves the right to request deposits and payments for outstanding balances. Deposits will be used on the outstanding balance plus the patient's share of the bill for the new services to be performed.

All outstanding balances greater than 45 days past due will accrue a monthly 15% interest penalty. All outstanding balances 120 days past due will be sent to a collection's agency. Advanced Therapy Solutions, LLC reserve the right to refer the account to an attorney and/or collection agency for attainment of the outstanding balance.

_____
Client Name & Date of Birth

936 Silas Deane Highway 3rd flr, Wethersfield, CT 06109, 860-721-9999
www.advancedtherapysolutionsct.com

_____ **[Clients with self-pay]**
The rate for evaluations, testing, reports writing, school visits, travel time and consultations will be $150.00 per 60 minutes for occupational therapy, $100.00 per 45 minutes for speech and language therapy.

I understand that I, as a self-pay client, may submit claims to my insurance company and that the clinic, per an established arrangement, will provide me with a monthly billing statement that includes all of the necessary information for submission such as diagnosis and procedure codes, dates of service, and this clinic's tax identification number.

_____ **[Clients with Insurance]:**

Verification of Insurance:
Because of the wide range of insurance plans in effect, the clinic will verify insurance coverage, deductibles and other limits, prior to acceptance for payment of services. This information is NOT a guarantee of actual reimbursement.

I, _____ will call my health insurance to verify benefit coverage for OT and/or Speech therapy coverage and notify the office at ATS.

_____ **Pre-Certification:**
Advanced Therapy Solutions, LLC will make every effort to pre-certify all services and procedures, provided that the clinic is supplied with the necessary information. Pre-certification and prior authorization does not guarantee payment of services. The parent/guardian of the child being seen at ATS is ultimately responsible for payment of services if the insurance company does not pay within 45 days.

_____ I understand that, if applicable, I must pay my insurance plan's co-payment/deductible/co-insurance prior to the treatment visit beginning.

_____ I understand that if Advanced Therapy Solutions is a recognized provider for my insurance company, they may bill my insurance company directly at my request, only when all of the proper insurance information is on record in the clinic's billing office**.** It is understood that insurance is filed as a courtesy to the patient and does not relieve the patient of financial responsibility. Processed claims will be held 45 days pending payment. The patient/guarantor will be responsible for payment in full on all claims not paid within the allowed period of time.

_____ **Rejected Claims:**
Coverage issues can only be addressed by my employer or group health administrator. Although our assistance is available, Advanced Therapy Solutions, LLC cannot act as my mediator on my behalf. Advanced Therapy Solutions, LLC will provide you with the necessary forms to file an appeal. All rejected claims must be paid within 45 days of having received a rejection.

Client Scheduling:

_____ I acknowledge that it can take up to 3 weeks for completion of a report and treatment plan.

_____ **Occupational Therapy:** I understand that a treatment session consists of **45 minutes** of direct treatment. An additional 15 minutes is used for parent consultation (five minutes), writing treatment notes and

treatment planning, and preparing the clinic environment for each child's individual needs. If additional time is needed for consultation, it can be provided by, ending the therapy session 5 – 10 minutes early, scheduling a meeting with the therapist, or scheduling a phone consultation.

_____ **Speech Therapy:** I understand that a treatment session consists of **30 minutes** of direct treatment. An additional 15 minutes is used for parent consultation (five minutes), writing treatment notes and treatment planning, and preparing the clinic environment for each child's individual needs. If additional time is needed for consultation, it can be provided by, ending the therapy session 5 – 10 minutes early, scheduling a meeting with the therapist, or scheduling a phone consultation.

_____ I understand that once my weekly treatment appointment schedule has been determined, this clinic is often unable to accommodate changes on a temporary basis. When a permanent change in time is needed, I must give as much advance notice as possible for the clinic to attempt to accommodate this request. A change may necessitate a change in therapist as well. When a therapist must initiate a permanent change of schedule, the therapist will give me at least a two weeks' notice and try to accommodate my needs.

_____ I understand that in order to receive maximal benefit from treatment, it is important for treatment to occur routinely. I understand that notification of vacations or family obligations is requested at least **two weeks** prior to the expected absence, to facilitate rescheduling the appointment(s).

Cancellation Policy:

_____ I understand that for sessions cancelled with less than 24 hours notice, a cancellation fee of $40.00 will be charged.

_____ I understand that if I *do not show for a scheduled session*, I will be charged $60.

_____ Cancellation and No Show fees will be due prior to scheduling any further appointments. This applies to ALL clients, both self-pay and those covered by insurance.

_____ I understand that sessions cancelled with more than 24 hours notice will not be charged a cancellation fee; however, the clinic encourages scheduling make-up sessions for these and all other sessions in order to ensure optimal progress.

_____ Repeated cancellations may result in the loss of my regularly scheduled timeslot. Advanced Therapy Solutions, LLC realize unexpected circumstances and illness arise, and Advanced Therapy Solutions, LLC will address these on a case-by-case basis.

_____ It is my responsibility and in my best interest to call the clinic to confirm my appointment prior to traveling in bad weather. The clinic's voicemail will be updated by 7:30 am to inform families of either a delayed opening or a closing due to inclement weather. Families may cancel treatment if they do not wish to travel because of poor road conditions. I understand that in the event of cancelling an appointment less than 24 hours notice due to inclement weather, I will not be charged the cancellation fee.

_____ I understand that when the therapist is ill or on vacation, every effort will be made to provide a substitute therapist to provide continuity of service. The clinic will make every effort to schedule a therapist at

my regularly scheduled appointment time. Every effort will be made to notify me with changes in scheduling, yet at times this may not be feasible.

Acknowledgment of Risk:

_____ I acknowledge that there is some risk inherent in the use of the therapy equipment at the clinic**. I agree to indemnify and hold Advanced Therapy Solutions harmless from any and all losses and claims for any injuries or other damages occurring to my child(ren) or myself or our belongings from the use of therapeutic equipment.**

_____ _____

Signature of Responsible Party **Date**

_____

Client Name & Date of Birth

936 Silas Deane Highway 3rd flr, Wethersfield, CT 06109, 860-721-9999
www.advancedtherapysolutionsct.com