Beckman And Associates, Inc.

Thank you for choosing Beckman & Associates, Inc. as your therapy provider. The following is the payment policy for this clinic.

______**Insurance**: We are a participating provider with United Health Care, BC/BS of Florida, Medicaid and Aetna. If you are not insured by a plan we do business with, payment will be expected at the time of service. If you are insured by a plan we do business with, we provide electronic submission of your therapy claims. **Please Note: Benefits quoted by your insurance company are NOT a guarantee of payment.** Please contact your insurance company with any questions you may have regarding your coverage.

All Clients with **out of network insurance coverage** must pay for services prior to being seen. All evaluation fees are to be paid at the time of service.

______**Proof of insurance**: All patients must complete our patient information form before seeing the therapist. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with correct insurance information in a timely manner, you are responsible for the balance of the claim.

______**Co-Payments and Deductibles**: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure to pay will result in rescheduling your appointment, unless an agreement has been made with the Client Care Coordinator.

______**Claims Submission**: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that the balance of your claims is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

______**Non-Covered Services**: Please be aware that some and even all, of the services you receive may be non-covered or not considered reasonable or necessary by your insurers. You must pay for these services in full at the time of service. Failure to pay for services rendered will result in a rescheduling of appointment, unless an agreement has been made with the Client Care Coordinator.

______**Non-Payment**: If your account has not been paid in 45 days, you will receive a letter stating that you have 10 business days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Failure to pay balance of your account within 30 days of the request for payment will result in a onetime charge of $25.00. After 30 days your account will be charged an interest rate of 1.5% monthly or 18% annually. In the event that we turn this matter over to a collection agency or to an

attorney, all fees and cost incurred with be the responsibility of the policy holder, legal guardian or responsible party.

______**Coverage Changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive maximum benefits. If your insurance company does not pay your claim in **45 days,** the balance will automatically be billed to you. Please help us serve you better by keeping your regularly scheduled appointments.

______**Missed Appointments**: Our policy is to charge a cancellation fee of **$25.00** for missed appointments not canceled within **24-hours** of your appointment time. These charges will be your responsibility and be billed directly to you. Please help us serve you better by keeping your regularly scheduled appointments.

I have read and understand the payment policy and agree to abide by these guidelines.

_____________________________ _________________________________

Name of Patient/Client **Date**

_____________________________ _________________________________

Signature of Responsible Party **Date**