KIDSTRONG
PHYSICAL THERAPY

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PATIENT NAME:_____ DOB:_____

Financial Policy and Agreement

I am very pleased and honored that you have chosen KIDSTRONG to provide physical therapy services for your child. I am committed to your child's treatment being a positive experience, and I want my billing process to be as straightforward and fair as possible. Please do not hesitate to contact me at any time with questions or concerns regarding this financial policy or any bills that you receive.

Regarding Insurance: I have developed a contractual relationship to be a provider of physical therapy services with a limited number of insurance entities. Your insurance policy is a contract between you and your insurance company. I am not a party to that contract or exactly what benefits are included or excluded in your plan. If I am contracted with your insurance entity, as a service, I will inquire about your policy's applicable benefit for physical therapy services. I encourage you to confirm this benefit, as I am not responsible if the benefit quoted differs from your insurance entity's actual payment. If I am not a provider for your particular insurance entity or if your insurance entity refuses to pay for any portion of the services rendered, the "Parent or Legal Guardian" will be billed directly and will hold full responsibility for any unpaid services.

The total amount of billed services and any applicable co-insurance or co-share will be due within 15 days of receiving your bill. I will accept both cash and check as payment options. A financial payment plan may be arranged if necessary on a case-by-case basis. Payments not received by the due date will be charged a $20 late fee, and any unpaid balances 30 days past due will accumulate 5% interest at the 1st of each new month that the balance is past due. If no payment plan has been arranged and a bill is more than 90 days past due, I reserve the right to contact a collection agency.

The late cancellation/no show fee is $50, and it is not billable to insurance. If you are unable to attend a session, please call a minimum of 24 hours ahead of time to cancel. If I am unable to answer, please leave a message on my voicemail. Please call to cancel as early as possible; however, it is understood that children may present symptoms of illness the morning of his/her therapy session. Parents will not be penalized for late cancellations due to illness. Please consider canceling a session if your child has vomited 2 or more times in a 24 hour period, or has a rash (especially with a fever or itching), diarrhea, thick/colored drainage from his/her nose, sore throat with fever or swollen glands, a fever of over 100 degrees within the last 24 hours, or he/she was kept home from school that day due to illness.

Assignment and Release: I authorize KIDSTRONG Physical Therapy, to release any information to my insurance entity that is pertinent to processing my claim. I have read this Financial Policy and understand that I am financial responsible for payment to Stephanie Figlioli, PT/KidStrong for physical therapy services not covered or contracted by my insurance entity. I understand and agree to this Financial Policy.

_____ _____
Signature of Parent or Legal Guardian Stephanie Figlioli, PT

_____ _____
Date Date