

Nimble Kids LLC d/b/a Comprehensive Therapy Children's Center

Financial Policy

_____ Patient's Name

We accept all major insurance companies with the exception of HMO's.

It is your responsibility to provide accurate and updated insurance information at each visit (or when your insurance changes). You will be responsible for any balances that your insurance carrier denies as a result of inaccurate information. Please check with our front office to insure your insurance information is accurate.

It is your responsibility to check with your insurance company to advise you on your coverage. Most plans are specific to your employer group and we do not know what is a covered benefit under your plan. Your employer benefit advisor at your place of employment will be able to answer your questions regarding coverage and benefits. If you do not have an advisor you can call the insurance company yourself.

It is your responsibility to insure that our therapists are covered under your health plan. If a referral or authorization is required, you must obtain this from your primary physician or health insurance company prior to your visit, otherwise you will be responsible for all charges.

You are ultimately responsible for any deductibles, co-pays and charges for services that you receive from our office. If your claim is denied or payment is not made within 30 days from the date of service, you must contact your insurance company for an explanation and pay us any amounts not paid by your insurance company.

Payment for deductibles and co-pays are expected the day of service.

You are ultimately responsible for payment of charges for services that you receive from our office. Any unpaid balances must be paid in full by the end of the month. Payment in full is expected upon your child being discharged.

This financial policy applies to children with Medicaid or Peachcare in the event their Medicaid becomes inactive.

We except only checks and cash (SORRY NO CREDIT CARDS).

There will be a 1% finance charge for any unpaid balance not paid at the end of the month and each additional month thereafter.

My signature below indicates that I have read and understand Comprehensive Therapy Children's Center Financial Policy and accept these terms. My acceptance covers my visit today and all future visits.

Parent or Legal Guardian Date