**PATIENT FINANCIAL RESPONSIBILITY AND ATTENDANCE AGREEMENT**

Thank you for allowing Thrive Therapy Associates, LLC to assist you with your child's therapy. We understand that you have many choices in providers and we are pleased that you have selected our practice.

In the interest of good health care practices, it is desirable to establish a financial policy to avoid misunderstandings. Our primary responsibility is to help our patients enjoy their therapy and get the most out of it, and we wish to spend our time and energy toward that end. Our goal is to make the financial aspect as stress-free as possible.

**As a courtesy to you**, we will bill your insurance or local funding source **if we are an in-network provider.** Please provide us with a copy of your Insurance card, so that we may make a copy. If there are any changes in your insurance, please let us know immediately so we can submit your claim properly. We cannot accept responsibility for collecting on an insurance claim after 60 days or for managing a disputed claim.

**Insurance reimbursement is a contract between you, your employer and your insurance carrier. You are responsible for any charges, or portions of charges that your insurance does not pay. We will contact your insurance company to see what therapy benefits apply to your specific plan. The information received is NEVER a guarantee of coverage, and you will have the final responsibility for understanding your insurance benefits and limitations and will be responsible for payment of services not covered by your insurance company, including but not limited to, deductible not being met, non-coverage due to the number of allowed visits being exceeded or a diagnosis not being covered. Thrive Therapy Associates, LLC reserves the right to terminate contractual agreements with health benefits plans without express written notice to the patient.**

**Co-Pays are due at the time of service.**

You will begin receiving monthly statements with any balances after your insurance company has been billed. If you have any questions about your charges or statement, please contact our office. The balance of the account is due within thirty (30) days.*

**CANCELLATIONS:** Thrive Therapy Associates, LLC requires 24 hours' notice for cancellations; otherwise, the patient will be billed for the session. Please contact us if you are not able to keep your scheduled appointment at least 24 hours in advance.
***For late cancellations and no shows***: You will be billed our Private Pay rates, for the duration of the missed appointment. (1 hour $135.00, 45 minutes $101.25, 30 minutes $67.50)

**ATTENDANCE POLICY:** We are committed to supporting the progress and success of our patients and their families. In order for us to see progression it is imperative that treatment is consistent. It is our policy that children attend 80% of scheduled appointments (8 out of 10 scheduled sessions). If you are not able to consistently attend appointments your child may be removed from the schedule.

I, the undersigned:

( ) have Medicaid insurance and/or DCBDD local funding coverage, and authorize direct payment from my insurance and/or local funding carrier to Thrive Therapy Associates, LLC.

( ) do not have Medicaid insurance and/or DCBDD local funding coverage and understand that I am responsible for payment of all charges.

**I have read this financial policy and understand that regardless of my insurance and/or local funding coverage or lack thereof, I am responsible for payment of my account. IF IT BECOMES NECESSARY FOR THIRD PARTY COLLECTION, I AGREE TO PAY ALL COSTS AND EXPENSES INCLUDING REASONABLE ATTORNEY FEES.**

**PRINT PATIENT NAME: ______________________________________________________________**

**PARENT/GUARDIAN SIGNATURE: ________________________________ DATE: ____________**