COMMUNITY THERAPY SERVICES
FINANCIAL POLICY: INSURANCE PARTICIPANTS

_____
Client's Name

Many insurance plans have deductibles, coinsurance, and copayments that are the client's responsibility. **Deductibles must be met before insurance will begin to cover the cost of therapy**.

I hereby represent and agree as follows:

1. I authorize CTS to discuss my insurance benefits with a representative of my insurance company.
2. I authorize the release of any medical or other information necessary to process any claims for services rendered.
3. I represent that the client, whose name appears above is covered by medical insurance, which will reimburse the charges for the treatment being provided to the best of my knowledge.
4. If my medical insurance does not cover certain aspects of my evaluation/treatment and/or is not sufficient to satisfy Community Therapy Services (CTS) charges in full, then I acknowledge that I am fully responsible for payment of my balance due for all services rendered.
5. I authorize CTS to receive payment directly from my insurance company. If my insurance company sends reimbursement for services rendered by CTS to my home or business, I understand my obligation to surrender any monies received within three (3) working days to CTS.
6. I understand that it is my responsibility to inform CTS of any changes in employer or insurance.

In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the amount owed as well as all reasonable costs associated with the collection of this debt, including but not limited to, collection services fees, attorney fees, and all court costs and additional fees associated with the recovery of this debt.

I have read this Financial Policy in its entirety, fully understand my rights and obligations under it, and agree to be bound to it. This agreement shall remain in force until the full balance with associated fees and costs have been fully satisfied.

_____ _____
Parent/Guardian's Signature Date

REQUIRED - AUTOMATIC BILL PAY AGREEMENT

At the end of the month, the credit or debit card that has been provided by you will be charged for all outstanding balances that are subject to the patient's responsibility. This includes deductibles, copayments and or co-insurance balances resulting from the insured's benefit plan.

Cardholder's Name: _____

Type: CREDIT/DEBIT HEALTH-FLEX SPENDING

Card Number: _____ Expiration Date: _____/_____

Cardholder's Signature: _____ Date: _____/_____/_____

OPTIONAL: Please contact me before charging my card if my balance is over $ _____.

(ph) 630-444-0077 (fax) 630-444-0078 (email) info@ctspediatrics.com