w o r k i n g   w o n d e r s   i n   c h i l d r e n ' s   l i v e s

THERAPYWORKS
Tulsa, OK 74133
ph 918.663.0606
fax 918.663.8754
www.therapyworkstulsa.com

Payment and Insurance Acceptance Policy

If you do not have insurance coverage, payment in full is expected when services are rendered. When you pay at the time of service, you will receive a 20% discount off of total charges billed.

If you have insurance coverage, co-payments and/or co-insurance, including deductible amounts, are due when services are rendered. TherapyWorks makes every effort to verify your insurance benefits before your initial visit. Your insurance company makes no guarantee of payment upon TherapyWorks calling and verifying your insurance benefits. We will proceed to file all claims with your insurance company. If there are insurance issues, we will provide all requested documentation to your insurance company and re-file claims again if necessary. If, for any reason, your insurance company declines payment, you will be responsible for payment of all outstanding services that have been rendered.

We require a 24-hour cancellation notice. If notice is received less than 24 hours prior to your scheduled appointment time, a $25.00 cancellation fee will be applied to your account. This fee also applies to missed appointments where no notice is given to our office. This fee must be paid at your next visit prior to seeing the therapist. Three (3) no-show appointments or five (5) cancelled appointments will result in all future appointments being removed from the schedule, at which time we will schedule you on a week-to-week basis.

If you have any questions regarding this policy, please do not hesitate to ask.

Patient Financial Responsibility and Assignment of Benefits

I hereby authorize TherapyWorks, Inc. to furnish my insurance company(s) or to designated attorney, all information that said insurance company(s) or attorney may request. I hereby assign to TherapyWorks, Inc. all payments which I may receive from the insurance company for medical expenses relative to the service rendered, but not to exceed my indebtedness to said clinic. It is understood that payments received from the insurance company(s) over and above any charges incurred, will be applied to my account as a credit to use against future co-payments or visit charges.

I understand that I am fully responsible to TherapyWorks, Inc. for all charges not covered by the assignment of my insurance. Many non-covered items may include Medical Necessity, Developmental Delay, Ineligible for Coverage, or Non-Covered Benefit. The patient will be billed for any outstanding balances on their account after insurance has either rendered a payment and/or a final decision on the status of the open claim. Payment Plans are available through our billing department. In the event of non-payment, I further understand that my account will be turned over to a collection agency for processing, which will cause irreparable damage to my credit ranking.

I have read the above and fully understand my responsibility for all treatment received.

____ ____________________
Patient or Guardian Signature Date

____ ____________________
Witness Date