Live Oak Children's Therapy

Financial Policy and Permission

(You must complete all highlighted areas. Thank you.)

_____ Primary Insurance

- **We will bill your primary insurance as a courtesy to you, if you provide all of the necessary information at the time services are rendered and agree to grant assignment of benefits to us.**
- **You are responsible for deductibles, copays, and coinsurance fees according to your insurance policy benefits.**
- **Payment is due at the time services are rendered.**
- **Some insurance companies reduce, limit, or exclude payments to providers who are not "in-network". You are responsible for the balance as indicated by your insurance policy benefits.**
- **In the event your insurance carrier denies your child's claims, Live Oak Children's Therapy will appeal denied claims once on your behalf. In the event these appealed claims are not paid within thirty days, you will be billed for the balance.**

_____ **Insurance Company**

_____ **Policy Number**

_____ **Policyholder Name**

_____ **Policyholder DOB**

___Secondary Insurance (Medicaid: WellCare, Amerigroup, Peach State Health Plan)

- **It is your responsibility to notify our office of any secondary insurance.**
- **If your child receives services through any of these payers, you must notify your therapist if your child's eligibility is inactivated to avoid being responsible for your child's therapy bill.**
- **Please be reminded that Medicaid limits allowed therapy per month. If you have given any other agency permission to bill Medicaid, it may affect our ability to receive payment, and may result in dismissal from treatment.**

_____ **Medicaid Number**

_____ **WellCare/Amerigroup Number**

___Private Pay

- **Please pay the balance in full upon receipt of your monthly statement.**

___Assignment of Benefits/Authorization to release medical information

- **I hereby assign all medical benefits to which my child is entitled to Fruin & Associates Inc, dba Live Oak Children's Therapy. In the event that insurance is filed on my behalf, I understand that I am financially responsible for all charges whether or not paid by said insurance. If my therapist finds it necessary to place my account with a collection agency, the collection fees will be added to my balance. I hereby authorize Fruin & Associates Inc, dba Live Oak Children's Therapy to release all information necessary to secure payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original.**

_____ **Responsible Party Name**

_____ **Responsible Party Signature**

_____ **Responsible Party SSN**

_____ **Responsible Party DOB**

_____ **Responsible Party Address**