DARLING PEDIATRIC THERAPIES, INC.

1475 Holcomb Bridge Rd., Suite #113, Roswell, GA 30076
678-591-3542 Fax: 770-234-6837 Email: DarlingOT@msn.com

FINANCIAL AGREEMENT – PATIENT GUARANTEE of PAYMENT

Darlene A. Robertson, OTR/L, Darling Pediatric Therapies and its agents hereafter referred to as **TSP** (Therapy Service Provider) agrees to provide therapeutic services, including but not limited to, Occupational Therapy, Physical Therapy, Speech Therapy or any therapeutic services offered by TSP, at the scheduled appointment times as agreed upon by and between TSP and the Patient, Patient's Guardian or other authorized Legal Patient Representative.

Patient Name:____

The Patient, or Patient's Guardian or authorized Legal Patient Representative, agrees that in consideration for the therapeutic services provided by and completed by TSP, at the scheduled appointment time, they will be held fully responsible for payment as listed below:

Cash Patients:

Therapy Services: ***Regular Rate***: $200 per 1 hour Session –
(a 32% discount ("*Regular Rate*" reduced by $65.00) will be given for any payment received within 30 days of the "date of service" for any therapy services rendered.)

Patient Evaluation: ***Regular Rate***: $350 per Evaluation –
(a 20% discount ("*Regular Rate*" reduced by $75.00) will be given for any payment received within 30 days of the "date of service" for any evaluation performed.)

Travel Expenses: A rate of $20 per home visit, will be added to any home therapy session visit. This is for travel and time.

Private Insurance Patients:

Patient is responsible for therapy service fees. Patient will receive the same discounted fees as a "Cash Patient" as long as they make payment within the 30 day time frame from the "date of service".

Any amount paid by Patient Private Insurance Provider will be deducted from the Therapy Services regular rate. If that amount paid by the Private Insurance Provider is less than the discounted rate for a "Cash Patient", Patient is responsible for the difference, to be paid within 30 days of payment received from Insurance Provider by TSP. If the payment is received after the 30 days, the Patient is responsible for the difference of the amount received from the Private Insurance Provider and the "Regular Rate".

Medicaid Patients:

TSP will bill your private insurance providers first. Then, Medicaid will be billed for the subsequent remainder as provided by Medicaid guidelines. TSP will accept the Medicaid reimbursement as payment in full. If Patient is denied Medicaid reimbursement for any reason, TSP will file and appeal if applicable. Should, on appeal, the Patient be denied reimbursement from Medicaid, the Patient is responsible for the payment for services rendered at the "Cash Patient" discounted rate.

Other Payment Patients:

TSP, from time to time, is a "Preferred Provider" of therapy services for specific private insurance carriers (e.g. Blue Cross/Blue Shield, Humana, etc.) and other governmental programs. If a Patient falls into this category, TSP will accept the contracted services payment as agreed between the Private Insurance Carrier/Governmental Program and TSP, as payment in full.

IMPORTANT NOTICE:

CHANGE OF INSURANCE INFORMATION

Patient must present his/her Private Insurance Provider card and information prior to any treatment. Should the patient switch their medical insurance coverage, carrier or status during the time of treatment, it is required for the patient to notify **TSP** immediately (prior to treatment). Failure of the patient to immediately notify **TSP**. of any insurance changes will make the patient fully liable for the full amounts billed for the services, which is due immediately upon request from **TSP.** Should **TSP** have received insurance reimbursement improperly because of insurance changes and information was not received, **TSP** is required to return the improper disbursement back to the insurance carrier. ***The patient is responsible for complete and immediate reimbursement for the full amount of returned funds.*** This amount is to be paid directly to **TSP** upon request

This form has been fully explained to me and I hereby acknowledge, accept and certify this by signing this Agreement. Further, I authorize the release of the Patient's requested Medical Records to my insurance company, Medicaid, Governmental Programs and other Health Insurance Portability and Accountability Act (HIPPA) compliant companies necessary to obtain payment for services rendered to my child.

I, ____

(Please Print Name of Patient Guardian, Patient or Patient Legal Representative)

____ do hereby authorize TSP

(Patient, Patient Guardian, Patient Legal Representative Signature)

to invoice for, and receive payment from Patient's Insurance Provider, for therapy services rendered to Patient.

Date:______________________________

Witness:____

____

(Witness Signature)

ATTENTION:

WE ACCEPT VISA, MASTER CARD, AMERICAN EXPRESS through our PayPal Account Please supply us with your E-Mail Address:______________________________