ADVANCE THERAPY
occupational, physical and speech therapy for children

FINANCIAL AGREEMENT 2024

CLIENT(s):_____

1. Medical Insurance: If requested, Advance Therapy will submit medical claims to your insurance company. Advance Therapy will help with verification of benefits under your insurance policy, however, you/the policy holder are ultimately responsible for obtaining and understanding covered services and exclusions. In the event that a claim is not reimbursed by the insurance company, you/the policy holder, are liable for payment.
   - I agree that Advance Therapy can bill my insurance for services rendered _____***initial***

2. All co-payments/co-insurance/deductibles are due either at the time of service, or billed on a monthly basis. Prompt payments will avoid additional fees. Invoices are billed monthly through Great Lakes Medical Billing, but payments should be made **directly to Advance Occupational Therapy, LLC (For OT and PT services) and to Advance Speech Therapy, LLC (For Speech services).**
   **There are credit card and cash/check payment rates.
   **Invoices overdue by 90 days may be turned over to collections.
   - I understand that I am responsible to pay all balances in full each month that my medical insurance does not cover _____***initial***
   - I understand that if Advance Therapy is unable to collect payment for services, my account will be turned over to collections _____***initial***

3. It is your responsibility to inform Advance Therapy of any and all changes in insurance and/or benefits/ reimbursement for services. This includes, but is not limited to group policy number and identification number. *Failure to do so could result in client/parent/guardian responsibility for charges.*

4. **Prior to receiving services at Advance Therapy, it is imperative that each family check their insurance coverage for the services that we provide.**

   Your medical insurance may only cover a portion of the service rendered and it is difficult to predict the exact cost to you. We require that you review the specifics of your plan to avoid any unexpected expenses. In order to do this you must contact your medical insurance provider and ask them the following questions:
   1. Is Advance Therapy in-network with my specific plan? ***Yes or No (circle one)***
   2. What is my current deductible: _____ and how much has been met to date? _____
      After I have met my deductible, do I have ***co-insurance:***_____ ***or a co-pay***: _____
   3. Are there any visit count limitations for speech therapy/occupational therapy/physical therapy included in my plan? ***Yes or No (circle one)*** If so, what is my visit limit:_____
      and have any been used date? _____
   4. Are there any exclusions (habilitative?) on my policy for speech therapy/occupational therapy/physical therapy? ***Yes or No (circle one)***
      If so, please explain._____

   For your records, write down who you spoke with, reference #, and the date of the conversation.
   Services at Advance Therapy are billed to insurance companies as an "office visit" and we are an "outpatient" office.
   - I understand that the information my insurance company provides me or Advance Therapy is not a guarantee of payment _____***initial***
   - I understand that I am responsible for understanding my insurance benefits _____***initial***

I, _____ agree to the terms and conditions listed above.

Client/Parent/Guardian signature:_____ Date: _____

Lino Lakes: 6776 Lake Drive #220 Lino Lakes, Mn 55014 Phone: 651-784-7007 Fax: 651-784-7992
White Bear Lake: 2555 Co Rd E East #102 White Bear Lake, Mn 55110 Phone: 651-683-2953 Fax: 651-705-0051
www.AdvanceTherapy.org