ADVANCE THERAPY
occupational, physical and speech therapy for children

FINANCIAL AGREEMENT

CLIENT(s):_____

1. Medical Insurance: If requested, Advance Therapy will submit medical claims to your insurance company for therapy services rendered. 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 as long as invoices are paid in full and within 30 days. By doing so, you will also avoid a finance charge of 1% per month. Invoices are billed monthly through Great Lakes Medical Billing, but payments should be made by check directly to Advance Occupational Therapy, LLC (For OT and PT services) and to Advance Speech Therapy, LLC (For Speech services). Invoices overdue by 90 days will be turned over to collections.
   - I understand that I am responsible to pay all balances 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, identification number, phone numbers, and address. 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. There are many unique medical insurance plans and they constantly change. 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 unplanned expenses. In order to do this you must contact your health insurance provider (this number is found on the back of your insurance card) 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? If so, what is my visit limit:_____ and have any been used date? _____
   4. Are there any exclusions on my policy for speech therapy/occupational therapy/physical therapy? If so, please explain._____

   ****It is best to write down who you spoke with, what was discussed, and the date of the conversation.***
   ****Services at Advance Therapy are billed to insurance companies as an "office visit" and we are an "outpatient" center.***
   - 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