



FINANCIAL AGREEMENT

Name of Client: _____ Date: _____

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 are due on a monthly basis and any outstanding 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 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 patient/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? **Y/N circle one**
 2. What is my current deductible set at and how much has been met to date? _____
 3. After I have met my deductible, do I have **co-insurance or a co-pay? Circle one**
If so, how much is it? _____
 4. Are there any visit limitations for speech therapy/occupational therapy/physical therapy included in my plan? If so, what is my visit limit and where is it at to date? _____
 5. 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: _____

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