Southlake Autism and Behavior Services, PA
355 Citrus Tower Blvd, Suite 116, Clermont, FL 34711
Phone: 352.223.1999 ⊙ Fax: 352.600.3119
www.southlakeautism.com

Payment Agreement

At Southlake Autism and Behavior Services, PA we are committed to providing your child with the utmost in quality services. In order to maintain this level of standard practice, timely payment must be received for services rendered. Payment is expected at the time of service unless other arrangements have been made in advance, or we are attempting to bill your insurance company. **Please note that insurance coverage does not guarantee payment for ABA services rendered. If your insurance company denies payment for any reason, you will be billed the contracted rate.**

- **For Privately Paying Patients**: Payment will be due at the time of service according to our current rate schedule.

- **For Patients With In-Network Insurance and Medicaid**:
  - Proof of insurance is required prior to your first appointment so that we may gather benefit information and obtain prior authorization if required to do so by your carrier.
  - Any co-pays and/or deductibles are expected at the time of service. This is legally required as per your contract with the insurance company.
  - We will submit therapy claims on your behalf, but please note this is **not a guarantee of payment**. If your insurance company denies part, or all, of the therapy claim, **you will be billed at the contracted rate for your carrier.**
  - We will make reasonable effort to assist you in collecting payment from your insurance carrier. If your insurance company requires submission of information from you directly, you will be expected to do so in a timely manner. **Claims that remain unpaid after 60 days will be billed to you directly.**
  - Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. If you have questions about your insurance benefits, please contact your carrier directly. We will happy to provide you with any necessary procedure and diagnosis codes they may require to answer your questions.

- **For Patients With Out-of-Network Insurance**:
  - Payment is due at the time of service using our current rate schedule.
  - We can provide you (upon request) with a receipt/ invoice containing proper coding that you can submit directly to your insurance carrier.
  - Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. If you have questions about your insurance benefits, please contact your carrier directly.

- **Non- Payment**: Account balances are expected to be paid prior to your next scheduled therapy session unless other payment arrangements have been made with an authorized Southlake Autism and Behavior Services representative. If your account has not been paid in full within 15 days, therapy will be put on hold until payment has been made. If your account has not been paid within 30 days, a late charge of $25.00 will be applied to your account balance, and every subsequent 30 days thereafter. In the event that we turn this matter over to a collection agency or to an attorney, all fees and costs incurred will be your responsibility.

- **Parents/Caregivers must read and acknowledge the statement below by initialing**

Initial As a courtesy, Southlake Autism makes every effort to advise Parents/Caregivers of what their deductible, copay, coinsurance or any other benefit will or could be. Parents are still required to check with their individual insurance companies to verify their benefits. Southlake Autism does not guarantee any information received from a client's commercial or government insurance company and transmitted to the Parent/Caregiver via voicemail, email, telephonic conversation, United States Postal Service or any other mail carrier to be true or accurate only to the extent that the insurance company provides accurate information related to ABA Services. All parents/caregivers understand that any differences in deductibles, copays, coinsurance or any other benefit information provided by Southlake Autism, as a courtesy, that differs from what their ins. company provides is still binding.

I read, understand, and agree to comply with the Payment Agreement of Southlake Autism and behavior Services.

Patient's Name:_____ Parent's Printed Name: _____

Parent's Signature:_____ Date Signed: _____