ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT

Assignment of Benefits: I hereby request that payment of authorized Medicaid, Peachcare for Kids and/or health insurance plan benefits be made on my behalf to Kidsplay Therapy Center, Inc. for therapy services provided. I authorize Kidsplay Therapy Center, Inc. to release to my third party payer / insurer and / or to the Health Care Financing Administration and its agents, if necessary, any medical information needed to determine the benefits payable for related services. I understand that I will be personally responsible for any amount denied, or any remaining amount owed for services partially covered by my third party payer / insurer.

Financial Agreement: I hereby authorize Kidsplay Therapy Center to: bill my insurance company, bill Medicaid, or bill myself for therapy received for my child. I understand that I will be responsible for any payment/deductible not covered by my insurance company/Medicaid.

I understand that I will be held responsible for assuring that my insurance and prescriptions are in good standing at the beginning of every treatment month.

I understand that it is my responsibility to inform Kidsplay Therapy Center of any changes that may occur in my insurance coverage.

Kidsplay Therapy bills your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment or your estimated share be made upon receipt of your billing. If your insurance carrier does not remit payment within sixty days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company.

I certify that I have read and understand the above.

_____

Client Name

_____ _____

Name of Guardian/Parent **Relation to Client**

_____ _____

Signature **Date**