Play2Grow
Developmental Therapy Services

8050 SW Warm Springs St. Suite 130 Tualatin OR 97062

www.weplay2grow.com

Financial Contract for Services

Re: (Person receiving services): ____________________________ DOB: ________________________________

Play to Grow Developmental Therapy Services is committed to providing you with the best possible care. If you have an insurance provider, we will give you an *estimate of your insurance coverage* based upon the information you provide us. As a courtesy to you, we will file your insurance claims. Please understand, however, that our relationship is with you, not with your insurance company. *Under no circumstances do we guarantee insurance coverage for your therapy.* Ultimately you are responsible for understanding the benefits and limitations of your insurance plan.

Please read and initial each section that follows:

_______ I understand that even when treatment services are listed as being a covered medical expense on my insurance plan, payment is not guaranteed. Upon receipt of claims for services rendered, my insurance company will complete a review for medical necessity and based on that review (related specifically to my case) the services *may not be considered to be medically necessary or may be* considered as *non-covered expenses* and may not paid by my insurance company.

_______ I elect to have Play to Grow Developmental Therapy Services provide treatment services. I understand that if my insurance company does not allow benefits or approve payment of claims for services received, or reverses its decisions on previously paid claims I am responsible for all incurred charges and agree to pay the balance in full.

_______ If insurance is billed by Play to Grow Developmental Therapy Services my insurance company may request information regarding treatment and I give my consent for the release of this information.

_______ I understand that as a condition of receiving insurance benefits I am responsible for paying all copayments determined by my insurance company at the time of service.

_______ I understand that if I elect to pay privately for therapy services I am responsible for the entire payment prior to, or at the time of service whether or not I have insurance benefits. If I elect to pay for private services I understand that I will at no time submit claims on these services to my insurance company as I am exercising my right under HIPPA to treat my child's treatment services as confidential matter.

______ I understand that there is a 24 hour cancellation policy unless there is a family illness or emergency on the day of service. If I fail to show for my appointment or cancel on the day of service without reasonable cause I may be charged a $35.00 cancellation fee.

I have read, understand, and accept the terms of the Contract for Services noted above

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Signature of Party Responsible for Payment ***Date***