Children's Therapy Associates, Inc.

Patient Financial Policy

☐ Self-Pay:	I agree to pay 100% of Fee Schedule at time of service.
☐ Medicaid:	Insurance will cover services. I agree to inform CTA of any insurance changes or termination as soon as I am aware of these changes. I will pay co-pays, if any, as indicated by my specific plan.
☐ Commercial Insurance: (Non-participating)	I will pay cost share, deductibles, and co-pays at time of service. If my insurance does not pay, I am aware that the bill is my responsibility. I understand that verifying my insurance's terms of payment is ultimately my responsibility.
☐ BCBS: ☐ UHC: (Participating)	I understand that co-pays, deductible amounts, and cost share amounts are due at time of service. Whatever the insurance does not pay becomes my responsibility. I understand that verifying my insurance's terms of payment is ultimately my responsibility.

I understand that any billed amount is due upon receipt, and services may be canceled if monthly payments are not received.

CTA accepts cash, checks, Visa, or MasterCard.

If your account remains delinquent after discharge, it will be forwarded to a collection agency. All fees assessed for such collection efforts, including agency and attorney fees, as well as court costs, shall be considered the responsibility of the guarantor and will be added to any claim presented.

If you must cancel your scheduled appointment, please give a notice so we may accommodate another who may need an appointment. If three (3) appointments are missed without canceling, CTA reserves the right to discontinue services for your child.

I authorize Children's Therapy Associates, Inc., to release to my insurance company general medical information, in addition to the diagnosis and records in the course of my child's treatment.

_____ Date: _____

Parent/Legal Guardian Signature

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