ATLANTA CHILDERN'S THERAPY ASSOCIATES, INC.
3597 Keswick Drive, Atlanta, GA, 30341
Phone: 678-313-3872
Email:

1. CONSENT FOR CARE AND TREATMENT:

I, the undersigned, do hereby agree and give my consent for Atlanta Children's Therapy Associates, Inc., to furnish _____ care and treatment to _____ considered necessary and proper in treating his/her physical condition.

Patient/Guardian_____ Date_____

2. BENEFIT ASSIGNMENT/RELEASE OF INFORMATION:

I, hereby assign all benefits to which I am entitled, including Medicaid, private Insurance and third party payors to Atlanta Children's Therapy Associates, Inc. A photocopy of this assignment is to be considered a valid as the original. I, hereby authorize and assignee to release all information necessary, including Medical Records, to secure payment.

Patient/Guardian_____ Date_____

3. FINANCIAL POLICY STATEMENT:

Atlanta Children's Therapy Associates, Inc. (hereafter referred to as "ACTA, Inc") shall provide speech and language, or occupational and or physical therapy services, and in return for those services, the Financially Responsible Persons (as indicated by signature below) primary insurance shall be billed first, followed by submission to secondary.

Initial:

_____ Private Insurance/BCW/FCP _____%. If Insurance does not pay or claim does not go to the deductible, family will owe $_____/visit.

_____ BCW covers 100%

_____ Private Insurance only. Your private Insurance will be billed. If no payment is received or insurance payment is less then $ _____, the payer is responsible for the residual up to $_____

_____ Private Insurance and Medicaid will cover 100%

_____ Medicaid covers 100%

_____ Cash pay: Family will owe $_____ /visit

Patient/Guardian_____ Date_____

ACTA, Inc. will bill the insurance carrier of the Financially Responsible Person as part of its services. However, the Financially Responsible person (as indicated by signature below) acknowledges that the financial obligation described herein is unconditional, and if the insurance company does not remit payment to ACTA, Inc. within sixty (60) days of the date the request for payment was submitted, the full balance will be due from the Financially Responsible Person. In the event that the insurance company request a refund for payments made after they have been paid to ACTA, Inc. the Financially Responsible Person will be responsible for the amount of money refunded to the Insurance Company. In the event the insurance company establishes an internal usual and customary fee schedule, the Financially Responsible Person will be responsible for any shortfalls.

If payment is made directly to the patient, of the Financially Responsible Person for services billed by ACTA, Inc. the Financially Responsible Person shall either: (1) promptly remit such payment for services to ACTA, Inc. with an explanation of benefits (EOB) with endorsement made and reassigned to provider; or (2) remit payment to ACTA, Inc. in the full amount received by the insurance company along with explanation of benefits (EOB) provided to patient or Financially Responsible Person.

Payments not received within 90 days of initial billing will be subject to a late charge of one and one-half percent (1.5%) per month (or portion thereof) compounded monthly until paid.

If Atlanta Children's Therapy Associates, Inc. takes any legal action to collect any amounts due from Financially Responsible Person for services provided, all legal fees, court costs, and other related expenses in their entirety which are incurred by ACTA, Inc. will also be due upon submission of appropriated documentation, notwithstanding the lack of prior notice to the undersigned as to the amount of fees, court costs, and related expenses.

By my signature below I hereby agree to be financially responsible for all the Child's financial obligations hereunder.

FINANCIALLY RESPONSIBLE PERSON

Patient/Guardian_____ Date _____

4. CANCELATION POLICY:

A charge of $40.00 will be billed after the 2nd "no-show" (child not available for treatment with any prior notice. In addition, we do require a 12 hour notice for cancellations. After the 3rd "no show" or repetitive cancels, without medical documentation, we do reserve the right to stop services.

Patient/Guardian_____ Date_____