Mini Miracles

PEDIATRIC THERAPY

Estimated Costs for Treatment

I understand this is an estimate of costs only. I understand I am responsible for payment each day of service.

Patient Name/DOB: _____

Insurance Company: _____

Estimated Cost: _____

Signature: _____

Date: _____

Registration, Billing and Collection Payment Policy

We are participating with Tennessee Medicaid, Virginia Medicaid, and Most Managed Care (commercial insurance) plans in the area. As a courtesy, we will file these claims for you. Patients are expected to pay any deductibles, coinsurance or copayment amounts owed at the time of service.

Patients with a third party coverage with whom we do not contract are responsible for payment in full at the time of service. As a courtesy, we will file your charges with this third party payer upon receipt of payment in full. Otherwise, we may provide you with a completed third party payer claim form to use in filing your insurance.

Patients that have not met their annual deductible amount on the date of service will be asked to pay Mini Miracles' estimate of the allowed charge at the time of service. You will be billed for any additional deductible amounts after the insurance processes the claim. After the deductible amount has been met, payment will reflect the appropriately allotted coinsurance amount.

Patients without verifiable insurance will be responsible for payment of all services rendered at the time of service following the Self-Pay Agreement Form.

Please realize, however, that:

- Your insurance is a contract between you and your insurance company. We are not a party to that contract. You are responsible to know your insurance benefits and the portion you are liable for.

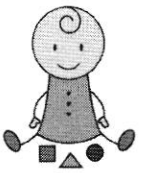
- Depending on the specifics of the agreement we have with your insurance company, any portion of our fees not covered may be the responsibility of the patient/guarantor.
- Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover. Any service not covered is the responsibility of the patient/guarantor.

Regardless of insurance payment, the patient and/or guardian remains responsible for all financial obligations incurred at the time of service. We realize that some balances may not be able to be paid in full at time of service. Please speak with the clinical director and sign the Payment Plan Policy and we will be happy to assist you in making payment arrangements.

By signing this financial policy acknowledgement of the financial responsibility is accepted. This will remain in effect until revoked in writing.

Parent/Guardian Signature: _____

Date: _____



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Patient Responsibility Agreement

Insurance Benefits

As a courtesy, our organization files insurance benefits on behalf of the client. It is the responsibility of the parent/guardian to ensure accurate insurance information is updated and on file at all times. Initial coverage information (primary, secondary, filing information) is obtained through this initial packet and will be updated yearly. Should you have any change to insurance coverage, please notify the front desk immediately to ensure proper billing.

Once payment amount is determined from the insurance, the parent/guardian is responsible for the remaining balance which may include deductible, co-pay, or co-insurance amount.

It is our policy for patient responsibilities to be paid at the time of service.

Private Pay

If you have chosen self-pay as the option for services, these payments are **due at the time of service.** You may also set up a plan to pay proactively each month if you prefer to pay in one large sum. Any remaining balance will be billed to you via monthly statement which will be due upon receipt of statement.

Monthly Statements

Any remaining balance will be placed on a monthly statement which is emailed to the email on file on the 5th of each month. This statement will list any remaining balance and include payments made to the account. **This balance is due upon receipt of the statement.**

Missed Payments

Should a payment be missed at the time of service, we ask that you make up this payment at the next time of service. **If payments are not received for a period of one (1) month OR if a balance of $350 is accrued at any point, a discussion will be initiated regarding prompt payment.**

If a balance reaches $500, there will be a discussion regarding a plan for paying balance in full and next steps for services which could include a change in the frequency of the plan of care or a hold on services. You will receive one courtesy text message alerting you to the effective date for the hold.

Child's Name: _____

Parent/Guardian Signature: _____

Date: _____