649 Barron Blvd
Grayslake, IL 60030
Fax: 847-278-0458 / Phone: 847-223-7433

Financial Agreement

- Family "Responsible Party" is responsible for the total amount of any charges for services provided to:

Child's Name: _____ Date of Birth: _____

. ❑ A copy of the "Responsible Party's" driver's license and/or valid state identification card must remain on file

- **A current credit card number and signature must be obtained to secure your scheduled appointment. An initial one time hold of $25 will be placed on this card.**
  - If you do not arrive for your scheduled appointment this amount will be applied to your account as a no-show charge (Please cancel your appointment 24 hours in advanced if no longer needed).
  - If you are scheduled for a free developmental screening the hold on your card will be released upon the completion of your appointment.
  - If you are scheduled for a speech evaluation the hold on your card will be applied to any insurance copay or expected patient due balance.

Credit Card (circle one): Visa or Master Card #: _____, Expiration (month/year): _____

Name as it appears on the credit card: _____Authorized Signature: _____

Billing address: _____

❑ **Yes** (I do) wish to have the listed credit card billed directly co-payments, patient portion and/or balance of insurance denials for each billing period. A receipt will be sent for charges posted.

❑ **No** (I do not) wish to have the listed credit card billed directly each billing period. However, I understand that a credit card must still remain on file with Pediatric Interactions, Inc and that any outstanding balance of an invoice (e.g., co-payments, patient portion and/or balance of insurance denials) that remains unpaid more than 60 days may be billed to the credit card on file.

- Payment for other services is expected within 30 days after the invoice date, which are sent monthly. If an invoice remains unpaid for 60 days, the 'responsible party' understands and gives Pediatric Interactions Inc. permission to automatically bill the credit card on file for the total amount due. Services may be placed on "hold" until balance is settled.
- Cash, checks, or credit cards (Visa,MC, Discover & American Express) are accepted payment options. Automatic payment, via credit card, can occur each billing period. A receipt will be emailed to the authorized representative of the account.
- Families with an attendance rate of less than 75% will be notified of their status and will be charged $25 for future missed appointments with less than 24 hours' notice. If a family "no-shows" for their appointment, they will be charged $25 regardless of cancellation rate. If the child wakes up sick or in case of inclement weather, please contact the office at 847-223-7433, your therapist by email, therapist direct line, or office (***office@pediatricinteractions.com***) before 8:30am and each circumstance will be taken into consideration before charging a late fee.

- Insurance
  -Billing discounts may be available to families who submit directly to insurance or do not submit to insurance and pay out of pocket
  -Verification of benefits does not guarantee payment by the insurance provider. Families should receive an Explanation of Benefits (EOB) from their insurance provider; however, upon any denial of claims, Pediatric Interactions should notify the family regarding the status and appeal process. After a final denial or partial payment from your insurance provider, Pediatric Interactions requires that the balance be paid in full within 30 days. Families are responsible for providing information regarding any changes in insurance status/policy or will be responsible for the full amount of any claims denied.

❑ I DO NOT intend to file claims for speech/language services to my health insurance and pay Pediatric Interactions in full for services provided. A "Billing Discount" will appear on invoices and must be paid within 30 days or the entire balance will be due.

❑ I allow Pediatric Interactions to file claims for and in consideration of the provisions of speech/language services. I hereby assign, transfer and set over to Pediatric Interactions all of my rights and interests in insurance benefits for the services rendered and authorize payment to be made directly to Pediatric Interactions. I understand co-payments, patient portion and/or balance of denied claims or partial payment are my responsibility and must be paid within 30 days after the invoice.

❑ A clear copy of the insurance card(s) (front and back) must be provided

- In the event the account becomes delinquent and is, therefore, in default of payment past the 30 days. The family or responsible party accepts responsibility for the principal amount owing, as well as all reasonable costs associated with the collection of this debt. This includes, but is not limited to, collection service fees, attorney's fees and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1.5% per months (18$ annually) for unpaid balances over 60-days old.
- If you have any questions regarding an invoice, payment or current balance, please contact our billing department at 248-601-9207 option 0.

I/we have received the billing information and understand that I/we am/are responsible for payment of services rendered. I/we therefore assume financial responsibility as stated above and responsibility for all collection and legal fees if my account becomes past due. I/we have read, understand, and agree to this "Financial Agreement".

Parent Signature: _____ Date: _____

Updated December 2012
subject to change