Financial and Benefits Information

CHILD'S NAME:_____

CHILD'S ADDRESS:_____

PRIMARY INSURANCE:_____

SUBSCRIBER/ID NUMBER:_____

EFFECTIVE DATE:_____GROUP#_____

PLAN NAME:_____

SECONDARY INSURANCE:_____

PRIMARY INSURANCE:_____

SUBSCRIBER/ID NUMBER:_____

EFFECTIVE DATE:_____GROUP#_____

PLAN NAME:_____

PARENT OR GUARDIAN/GUARANTOR INFORMATION

PARENT/GUARDIAN'S
NAME:_____

ADDRESS:_____

EMPLOYER:_____

CELL PHONE NUMBER:_____

SSN:_____

Movin' & Groovin' Children's Therapy Services, Inc.

Thank you for choosing **Movin' & Groovin' Children's Therapy Services, Inc.** for your pediatric physical therapy needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies. Your insurance, third party payor, is billed as a courtesy of this practice.

Patient (or Patient's guardian, if a minor) Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care should understand your policy benefits and exclusions.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance and is ultimately responsible for charges not covered, denied or unpaid by insurance or other third party payor.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
    - Charge for returned checks - $30.00

By my signature below, I hereby authorize assignment of financial benefits directly Movin' & Groovin' Children's Therapy Services Inc. for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient Name _____

Patient/Guardian Signature _____

Date _____