Our company has been contracted to serve your child for his or her developmental needs. We will be providing Physical Therapy, Occupational Therapy, Speech Therapy, or a combination of these services for your child in order to assist the child in developing efficiently. If the child does not have insurance, or insurance denies payment for any reason, it will be necessary to send you a monthly invoice for services previously rendered so that the child’s account remains current. This document serves as a binding contract between Full Circle Pediatric Therapy, Inc. (FCPT) and the patient’s parent or guardian, assuring that these payments are promised. By signing this document, you agree to pay FCPT for any evaluations, assessments, or treatments previously rendered for the child for whom you are responsible. Your signature also signifies that you understand that if regular payments for these services are not received by FCPT, FCPT reserves the right to cancel future services until such time as the account is brought to a current status, or until such time as a payment plan has been established (and regularly paid) to the satisfaction of FCPT. Delinquency beyond six (6) weeks may cause the child to be discharged permanently from FCPT. FCPT reserves the right in these rare cases to use a collection agency in order to bring the account current. **Take note!** If the child is a valid recipient of Medicaid and you are receiving bills for services or supplies that are covered by Medicaid benefits during a time for which Medicaid was/is active, any such medical bills are considered illegal. In such cases, you have the right to simply send a copy of the Medicaid card to the billing company showing the dates of coverage that cover the service dates for which you are being billed; that company may no longer contact you regarding that bill.

Please initial below, signifying agreement with the following statements:

* I understand it is mandatory for me to sign this contract in order to receive services
* I understand that I must give my Social Security # in order to receive services
* I understand I will be responsible for any unpaid balance accrued (unless Medicaid)
* I understand that, if applicable, I will be invoiced for any services and be expected to pay within 2 weeks of receiving any invoices
* I understand that services may be cancelled or placed on hold indefinitely if my account is past due
* I understand that my child can be discharged based on non-compliance with this contract

My signature below signifies my financial responsibility for the minor child (Patient’s Full Name),      .

Signed by [ ]  Primary Caregiver/ [ ]  Parent/ [ ]  Legal Guardian (check applicable):

Name:       On Date:

Signed by [ ]  Secondary Caregiver/ [ ] Parent/ [ ]  Legal Guardian (check applicable):

 Name:       On Date: