PEDIATRIC THERAPY PARTNERS

640 Enterprise Drive Ste C Lewis Center, Ohio 43035 614.433.0132 www.ptpohio.com

Your signature below forms a binding agreement between Pediatric Therapy Partners Practice (PTP - the provider of therapy services) and the Patient who is receiving medical services or the Responsible Party for minor patients (those patients under 18 years old).

Responsible Party is the individual who is financially responsible for payment of medical bills. All charges for services rendered are due and payable at the time of service.

MEDICAL INSURANCE and MEDICAID: *By signing below you are agreeing to allow us to bill your insurance on your behalf. As the responsible party, you are responsible if your insurance company declines to pay for any reason.*

The person signing on behalf of the Patient as the Responsible Party must:

- Inform PTP of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to beginning therapy, if there are any changes, and at the beginning of each year.
- Pay any required co-pay or patient responsibility at the time of service.
- Pay any additional amount owing within 30 days of receiving a statement from our office.
- Accounts over 90 days may be sent to collections.

Returned Check Policy
If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $25.00 Service Charge. Once notice is received of the returned check, PTP will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance – in addition to the $25.00 Check Service Charge.

By signing below, you agree to accept full financial responsibility as a patient who is receiving therapy services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print)

Patient Signature Date

Responsible Party Name (Please Print)

Responsible Party Signature Date