WAUWATOSA THERAPIES, LLC
PEDIATRIC THERAPY SPECIALISTS

POLICY STATEMENT AND FINANCIAL AGREEMENT

1. Insurance: It is the responsibility of the patient or the patient's guardian to inform Wauwatosa Therapies of any and all changes in insurance information. Failure to do so could result in total patient responsibility for charges incurred. The undersigned agrees to promptly pay any co-pay, coinsurance, deductible, or non-covered service.

Wauwatosa Therapies will file claims with your personal insurance company and verify your insurance benefits; however this does not guarantee payment for therapy services. When insurance does not provide payment of therapy costs, payment of the bill is the patient's responsibility.

My signature below indicates authorization for payment to be sent directly to Wauwatosa Therapies for any claims submitted to an insurance company or Medicaid on my child's behalf. For patients with Medicaid, you will only be responsible for services that are denied by Medicaid, which includes treatment sessions for which Prior Authorization was requested but denied. For these services and self-pay clients, you will be billed a cash rate of $65 per session.

Wauwatosa Therapies allows parents / guardians to leave the facility during the child's scheduled appointment. If you leave during the therapy session, you must provide Wauwatosa Therapies with a cell phone number, in which to reach you, before leaving. By signing below, you agree to give WT permission to call 911 or Emergency Medical Services in the event of an emergency during your absence.

_____ _____

Child's name Parent / Guardian Signature

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Date

*Updated 1/2014