BECKMAN AND ASSOCIATES, Inc.

Thank you for choosing Beckman & Associates, Inc as your therapy provider. The following is the payment policy for this clinic.

_____ Insurance: We are a participating provider with United Health Care, Blue Cross and Blue Shield, and Aetna. If you are not insured by a plan we do business with, payment will be expected at the time of service. If you are insured by a plan we do business with, we provide electronic submission of your therapy claims. **Please Note: Benefits quoted by your insurance company are NOT a guarantee of payment.** Please contact your insurance company with any questions you may have regarding your coverage.

_____ All clients with **out of network insurance** coverage must pay for service at the time of service. All evaluation fees are paid at the time of service.

_____ Proof of Insurance: All patients must complete our patient information form before seeing the therapist. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with correct insurance information in a timely manner, you are responsible for the balance of the claim.

_____ Co-Payments and Deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

_____ Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. It is your responsibility to comply with their requests. Please be aware that the balance of your claims is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

_____ Non-Covered Services: Please be aware that some and even all, of the services you receive may be non-covered or not considered reasonable or necessary by your insurers. You must pay for these services in full at the time of service.

_____ Non-Payment: If your account has not been paid in 45 days, you will receive a letter stating that you have 10 business days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated.

_____ Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive maximum benefits. If your insurance company does not pay your claim in **45 days**, the balance will automatically be billed to you.

_____ Missed Appointments: Our policy is to charge a cancellation fee of **$25.00** for missed appointments not canceled within **24-hours** of your appointment time. These charges will be your responsibility and be billed directly to you. Please help us serve you better by keeping your regularly scheduled appointments.

I have read and understand the payment policy and agree to abide by these guidelines.

_____ _____

Signature of Insured Person **Date**