metamorphosis THERAPY, LLC

Transforming through Therapy

financial responsibility

Patient's Name : _____

Primary Insurance or Private Pay? _____

For participating insurance plans- I authorize the release of any information necessary to process medical claims for the patient named above and authorize that payment of benefits for these claims be made to Metamorphosis Therapy, LLC. Also, I agree to promptly pay for any services not covered by my insurance and or determined to be my responsibility (i.e., Deductibles, Co-payments such as 20% of the allowable fee for Medical Services when deemed "Reasonable and Necessary"). Insurance covers the cost of 30 minute sessions for both Occupational and Speech Therapy. If you would like additional therapy for your child we will be billing you for the following additional therapy in 15 minute increments and the rates are as follows:

45 minutes session (additional 15 minutes)..... $25

60 minute sessions (additional 30 minutes).....$50

Private Pay – Not using insurance; I am paying by cash, check or credit card at the time of service. You have been offered the opportunity to personally pay for treatment at Metamorphosis Therapy, LLC.

The private pay policy is used in the following circumstances:

1. Patient has no insurance.
2. Therapy is not covered by patient's insurance.
3. Patient chooses to forgo insurance benefits.

The following conditions apply:

1. Once you have chosen the private pay terms, we will not bill your insurance carrier for services rendered.
2. We accept cash, debit, credit, or checks. There is a $25.00 service charge for returned checks.

Payment is due at the time services are rendered. I agree to these payment terms and guarantee payment to Metamorphosis Therapy, for any services provided to the patient named above.

_____ _____

Signature of Guarantor Date

Relationship to Patient: □ Self □ Spouse □ Child □ Other:_____