Helping Hands Therapy Services, PLLC
Virginia Beach, VA
Phone: 757-550-0725 **Fax: 888-306-7078**

www.helpinghandstherapyservices.com

FINANCIAL POLICY

I, the undersigned, whether signing as a patient, agent, or parent/guardian, agree to pay for services rendered in accordance with the regular rates and terms of Helping Hands Therapy Services. As a courtesy, Helping Hands Therapy Services will verify insurance benefits and file claims on my behalf. I understand that insurance policies are contracts made between the patient and the insurance company that verification is not a guarantee of payment for services. **I understand that if my insurance does not provide payment of therapy costs, or finds that the services rendered are not a covered benefit, I am responsible for the payment of services, even if my insurance finds no financial liability on my behalf.** If for any reason treatment is denied by my insurance carrier, I understand I will be responsible for the usual and customary amount assessed by my insurance company.

Initial Here:

I understand that I am responsible for any deductibles/co-pays/co-insurance amounts assessed by my insurance carrier.

Initial Here:

I understand it is my responsibility to inform Helping Hands Therapy Services of any and all changes in insurance information, including group policy number, identification number, phone numbers, addresses, etc. as soon as possible. **Failure to do this could result in total patient responsibility for charges incurred**.

Initial Here:

I understand that Helping Hands Therapy Services is not a provider for outpatient therapy with Virginia Medicaid (with the exception of Medicaid HMO's). **I understand that if I have Virginia Medicaid as a primary or secondary insurance and I choose Helping Hands Therapy Services as a provider, I will be responsible for any co-pays and deductibles not covered by the primary insurance**. I also understand that I cannot submit the claims myself to Medicaid to request reimbursement.

Initial Here:

I will remit all payments on my account within 30 days of receiving my statement. I understand that payment arrangements may be available. I understand that I will be responsible for any/all collections, court, and/or attorney fees associated with the collection of my account. I also understand that if a check is returned for insufficient funds, I will be charged a $45.00 service fee in addition to the face value of the check.

Initial Here:

I understand I may be charged for therapy products, educational materials and for other administrative expenses, including copies of medical records, not covered by my insurance plan.

Initial Here:

I authorize the release of any medical or other information necessary to process claims. I give permission to bill my insurance and for the payment of benefits to be released directly to Helping Hands Therapy Services for all services provided and claimed.

Initial Here:

This form has been fully explained to me. I understand its contents and terms. My signature below certifies acknowledgement and acceptance of this financial agreement between Helping Hands Therapy Services and myself.

Client Name: DOB:

Responsible Party Signature:

Responsible Party Name/Relationship Date: