Partners in Learning, Inc.

Statement of Client Financial Responsibility

Client Name: _____ DOB: _____

Partners in Learning, Inc. appreciates the confidence you have shown in choosing us to provide for your ABA needs. The service you have elected implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your BCBA elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Partners in Learning, Inc., for providing ABA services to my child/dependent. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Partners in Learning, Inc., the full and entire amount of bill incurred by me or the above-named client; or, if applicable any amount due after payment has been made by my insurance carrier. I agree to notify Partners in Learning, Inc. immediately regarding any change in my insurance coverage.

Parent/Guardian Signature_____ Date _____

Guarantor Signature _____Date _____
(If guarantor is not the parent)

Co-Pay Policy

Some health insurance policies require the patient to pay a co-pay for services rendered. While daily co-pays in the medical field are routinely collected at the time of service, the nature of our service creates some difficulty in this process. For this reason, we invoice for any applicable co-pays on a bi-weekly basis. If co-pays are not paid according to the terms stated on the invoice, services may be suspended until payment is received.

Thank you for your cooperation in this matter.

Parent/Guardian Signature _____ Date _____

Cancellation / No Show Policy

We understand there may be times when you need to re-schedule an appointment due to emergencies, illness or obligations to work or family. However, we urge you to call at least 24-hours prior to canceling your appointment if possible. Since our staff are paid for sessions scheduled and then cancelled with less than 24 hours notice, in these cases, regretfully we must bill a minimum of one hour of the scheduled session. This amount is not covered by insurance and is the responsibility of the client.

I understand if I cancel, and fail to provide adequate notice for cancellation, all further cancelled sessions may be billed to me in full, at the current contracted insurance rates, and based on the number of hours originally scheduled. After five cancellations without adequate notice, my child/dependent may be discharged from the program.

The business manager will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Parent/Guardian Signature _____ Date _____