PARTNERS IN LEARNING, INC.

Teaching to the ♥ of What Matters

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 of our fees in full. You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. PIL makes every attempt to provide clear and accurate financial responsibility information, however we recommend you also speak with your carrier directly to ensure you fully understand the way in which your insurance policy will apply patient responsibilities.

Co-Pay & Co-Insurance Payment Policy

PIL utilizes an ACH Direct Payment process for collecting patient responsibilities. Payments are processed on a weekly basis via a withdrawal from the checking or savings account that you provide on the CoPay ACH Withdrawal Authorization Form. This form must be completed and returned prior to services beginning. A schedule of the payment dates, including the date PIL submits the payment to our bank, the date the payment is withdrawn from your account, and the service period for which each payment covers will be provided. Please review the schedule carefully so that you can plan for the withdrawals each week. In the event a payment is declined for insufficient funds, a $20 bank fee will be assessed to you and added to the current payment when resubmitted. Repeated neglect of the terms of this policy may result in a daily payment requirement for all future co-pay or co-insurance payments.

**Note: If your insurance policy includes an HSA or FSA account that you intend to use for payment of your patient responsibility amounts, please contact us to discuss the additional information needed.*

Cancellation / No Show Policy

Our policy requires parents to give at least 24-hours notice prior to cancelations of scheduled therapy sessions. 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 repeated violations of this policy may result in additional fees charged to you that are not covered by your insurance carrier.

I have read the above policy regarding my financial responsibility and supplemental obligations to Partners in Learning, Inc., for ABA services provided to my child/dependent. I authorize my insurer to pay any benefits directly to Partners in Learning, Inc., the full and entire amount of bill incurred by me for the above-named client; or, if applicable, I agree to pay 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)

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