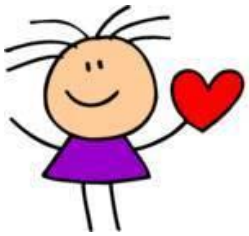

Hope's Playground Pediatric Therapy

Clinic Policies

Acknowledgement of Financial Responsibility

I understand that Hope's Playground Pediatric Therapy, Inc. will submit my insurance claims on my behalf. I authorize my insurance company(ies) to pay directly to Hope's Playground Pediatric Therapy, Inc. all benefits due under the policy(ies) for services rendered. I agree that, if for any reason, my insurance company(ies) fails to reimburse any portion of a claim for services rendered at this clinic, it is my responsibility to pay what is owed to Hope's Playground Pediatric Therapy, Inc. I understand that co-payments are due in full at the time services are rendered. Should my account become delinquent and be referred to any third party for collection efforts, I agree to pay all reasonable attorney's fees, court fees, and collection expenses.

Insurance Pre-Certification and Benefits

I understand that information received by Hope's Playground Pediatric Therapy, Inc. regarding my insurance policy limits, co-payments, and deductibles is based on Hope's Playground Pediatric Therapy's contacts with my insurance company. I understand that based on insurance company(ies) disclaimers, accurate information on policy limits, co-pays, and deductibles may not be ascertained until my insurance company receives a bill and payment is processed. I agree to notify Hope's Playground Pediatric Therapy, Inc. prior to making changes regarding my insurance coverage. I understand that if I change insurance companies without notifying Hope's Playground Pediatric Therapy, Inc., any subsequent denials of payment for services rendered will be my responsibility.

Late Fee

I understand that I am responsible for all co-payments, insurance deductibles, and private payments for services in a timely manner. I understand that I am subject to a $25 late fee for any payments received after 60 days of the invoice date.

Financial Hardship

Hope's Playground Pediatric Therapy, inc. understands that certain situations may arise and cause financial hardship. Hope's Playground Pediatric Therapy is committed to providing optimal care for your child regardless of financial status. If you are unable to pay for the pre-determined rate of services, co-payments, and/or deductibles, you must provide written notification to Hope's Playground Pediatric Therapy, Inc. detailing the circumstances warranting a need for a reduced fee or payment plan. Completion of a personal financial statement form is required to be completed for our consideration. If granted, reduced fees will be provided for a period of six months. Prior to the end of the six months, if circumstances have not changed, parents may request an extension in writing.

Broken or Missed Appointments

I understand that Hope's Playground Pediatric Therapy reserves the right to charge for broken or missed appointments without 24 hours notice. I agree to pay these charges. I understand that after 3 no-shows, my child may be denied further treatment. Hope's Playground Pediatric Therapy, Inc. understands that sometimes situations arise when a cancellation is inevitable. However, please be considerate and cancel appointments at least 24 hours in advance whenever possible and show up on time for scheduled sessions.

Pick-Up/Drop-Off

I understand that I am responsible for being on time for scheduled therapy appointments. I recognize that my tardiness may delay the therapists' future appointments and will reduce the length of my child's therapy session. If my child is late to therapy, the therapist will not be able to make up the missed time at the end of the session. I understand that Hope's Playground Pediatric Therapy, Inc. allows me to leave the clinic while my child is receiving therapy as long as I return to pick my child up at least ten minutes prior to the end of the session. Hope's Playground Pediatric Therapy, Inc. reserves the right to require me to stay during my child's treatment sessions.

Treatment Sessions

I understand that my child's treatment session will last for 1 hour. My child's therapist will spend 50 minutes directly treating my child. I will have the remaining 10 minutes to discuss my child's session with the therapist and ask questions if necessary. I will also allow time for my therapist to document the day's session at this time. I can request a copy of the therapist's note for my records which will be provided to me at the conclusion of the hour or at the next treatment session depending on available time.

Authorization for Release of Medical Records and Information

I hereby consent to disclosure of any records of information concerning the treatment of my child maintained by Hope's Playground Pediatric Therapy, Inc. for the purpose of insurance claims, or other claims for medical benefits, and for the exchange of information to the patient's physician, psychologist, therapist, or other source if appropriate.

I have read all of the above and understand my responsibilities. I understand that my signature is required in order to receive services from Hope's Playground Pediatric Therapy, Inc.

_____ _____

Print Patient Name Date

_____ _____

Signature of Guardian Relationship to Patient