All Aboard Pediatric Therapy, LLC
CONSENT FOR BILLING

We are pleased to be able to provide services to your child. Because there are so many children who need our services and money is limited, we are required to make use of all possible sources of funding to meet the needs of children. The first source of funding is your family's private health insurance/HMO and/or Medicaid. If we do not follow the State law and access your child's private health insurance/HMO and/or Medicaid first, then we are unable to seek funding from other sources. If you decline billing of your family's private health insurance/HMO and/or Medicaid, you may be responsible for the entire cost of your child's therapy.

Access of your private health insurance/HMO benefits by AAPT should not pose a realistic threat that you or your child will suffer a loss of insurance/HMO benefits. Access of your insurance/HMO will only be done with your approval. The patient shall be financially responsible for any portion of the invoice that is not paid, except in the event of covered services provided to Medicaid recipients. The undersigned agrees to execute any and all documents and perform any acts that AAPT may reasonably request to ensure that all third party benefits for therapy services are paid.

Your voluntary permission is required in order for AAPT to submit a claim to your insurance/HMO carrier. If you understand and agree to our submitting a claim to your insurance/HMO carrier, please check the appropriate box below and sign this form. With your signature, you authorize direct payment of medical benefits to AAPT and that you understand that you are personally responsible to the AAPT for charges not covered or paid for by your insurance/HMO.

We are required to bill Medicaid for services provided to Medicaid recipients. We do not need permission to do so.

Child's Name:
_____

Child's Date of Birth:
_____

Parent//Guardian Name:
_____

Relationship to Child:
_____

Please check **all that apply**:

□ I give my permission for AAPT to bill my private insurance/HMO for services provided to my child by the program. I hereby agree to pay co-pays and deductible. (If co-pays and deductibles are a financial hardship please see the office manager for assistance). I also authorize release of medical information necessary to process this claim.

□ I have Medicaid coverage for my child.

□ I do not have any form of insurance coverage or Medicaid.

□ I have private insurance/HMO coverage but I **DO NOT** want AAPT to bill my Private Insurance Company or HMO and understand that I may be responsible for the cost of my child's therapies.

Signature: _____ Date: _____

Please make sure we receive a copy of your insurance card and/or ID upon arrival at your first visit. AAPT will file claims with up to two insurances on your behalf; you will be responsible for filing any additional claims. We will verify your insurance coverage before your initial evaluation and inform you of your child's benefits at your first visit. This is not a guarantee of benefits. If you have an insurance co-payment it will be collected when you sign in at each visit.