DISCOVER THERAPY

FINANCIAL POLICY
227-B Bendel Rd Ste C, Lafayette, LA 70503
P: (337) 981-9940 F: (337) 981-2531
www.discover-therapy.com

PLEASE READ CAREFULLY

Thank you for choosing Discover Therapy, Inc. to provide services to you and/or your child. Our main concern is that proper and optimal treatments are provided to meet individual needs. Therefore, if you have any questions, concerns, or comments, please do not hesitate to speak with our director.

PAYMENT TERMS

All payments for services rendered are due at the completion of each treatment session. Clients can choose to pay for services rendered upon the completion of each treatment session or at the end of each month; however, all accounts must be cleared by the end of each month in order to continue services. **Upon your acceptance of our service we will secure a credit card from you which will be used to pay for services in the event you choose not to pay for services by other means.** This credit card will be billed at the end of each month for services rendered that month unless you choose to pay by some other means. As discussed below we will attempt to collect from your insurance company any monies that are owed on your account. If we collect any monies owed on your account from your insurance company we will credit your account or your credit card for those monies paid. As discussed below, collections from your insurance company is a courtesy service we provide. As our customer, you are ultimately responsible for the bill; thus, your balance must be cleared every month regardless of what your insurance company has or has not paid.
_____Initial

PAST DUE ACCOUNTS

Open accounts with balances greater than 30 days will be considered past due. _____ Initial

COLLECTIONS

Open accounts with no acceptable payment activity for 90 days will be automatically placed with our attorney and/or a credit bureau. Please be aware that if this happens, you are responsible for the original past due balance along with any additional charges incurred from these agencies and/or associated court costs. _____Initial

CANCELLATIONS/RESCHEDULING

A 24-hour cancellation/reschedule notice is required before your appointment time. Any cancellations made less than 24 hours, but greater than 3 hours prior to the scheduled appointment time will result in a $15 cancellation fee. All cancellations made less than 3 hours prior to the scheduled appointment time will result in a full charge at the rate of a normal office visit. This fee is NOT billable to insurance. _____ Initial

REGARDING INSURANCE

This office will file insurance for our clients in which insurance benefits may apply once the necessary insurance information is provided. This is a courtesy that we provide, but please remember that you have the contract with your insurance company and are ultimately responsible for payment. We cannot accept responsibility for collecting from your insurance company nor negotiating a settlement on the disputed claim, however, our insurance director is available if you need assistance. **Remember you are the holder of the insurance contract; it is your responsibility to make sure you understand the contract between you and your insurance company, and you know your benefits for the policy.** For all treatment, evaluations. Or other service charges provided by our facility that are paid in advance we will attempt to collect from your insurance that amount paid for a period of 90 days. However, if after this period insurance has still not paid, we will no longer attempt collection and any reimbursement you may seek from your insurance company will be your responsibility to collect. Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. You are responsible for payment in full regardless of an insurance company's arbitrary determination of usual and customary rates. _____Initial

Again, thank you for choosing Discover Therapy, Inc. to serve and assist you and/or your child.
I have read and understand this policy.

_____ _____
Responsible Party Signature Date

Print name: _____