



Financial Policy

- We will gladly try to answer any questions related to your insurance, but insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. You must realize that your insurance is a contract between you, your employer (possibly), and the insurance company. We are not a party to that contract except where we are contracted as preferred providers.
- If we do participate with your insurance company, all services performed in our office or in the community will be submitted to your insurance. All co-pays and deductibles are your responsibility and are due at the time services are rendered.
- If we do not participate with your insurance company, we will not bill your insurance carrier. Unfortunately, due to nonpayment from a number of insurance companies we are unable to wait for your insurance payments. We will give you monthly invoices for you to submit to your insurance company on your own, as long as you have paid your balance in full. Most insurance companies take at least 60 days to pay our claims. We appreciate your understanding.
- We must emphasize that as therapy practice, our relationship is with you, not your insurance company. While the filing of in-network insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from the date services are rendered. Therefore, it is often necessary for you to inquire and explore your benefits with your insurance carrier. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our business office for assistance in the management of your account.
- I understand that payment for services is due at the time services are rendered. Any outstanding balances are due within 30 days, unless prior arrangements have been made with the Business Office. All balances that reach 90 days or older may be sent to a collection agency. **All accounts sent to a collection agency will be charged an additional 18% collection fee.**
- I have read and fully understand the financial policy set forth by Star Therapy, Inc. and I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby assign all medical benefits to which I am entitled, including Medicare, Private Insurance and any other health plan to Star Therapy, Inc. This assignment is to be considered as valid as the original.

Child's Name

DOB

Date

Signature of Parent or Guardian