Terms of Payment Agreement

This is not an online form. Please print the form, fill it out and bring it to your appointment. Thank you!

We reserve regularly scheduled appointments for our clients. In consideration for all clients we start and end the sessions at the regularly scheduled time and appreciate our families' cooperation in this policy. We believe that children who come consistently to therapy make the most progress, however, we do understand that there are times it is necessary to cancel a session. We ask for 24 hours notice if you find you cannot make your appointment. Last minute cancellations (i.e., less then twelve hours before the designated appointment) and /or no calls, no shows will be billed for the treatment session missed and the invoice will reflect that information appropriately. Exceptions to the cancellation policy will be made for children who are ill upon awakening only if notice is received by 8 am. Therefore, please call and leave a message at the office first thing in the morning if your child is sick. If you wait until right before the appointment to call and cancel, you will be billed for the missed appointment. If weather is bad we will be contacting you to discuss arrangements, or if you know you cannot get here, call and leave a message on your therapists' voice mail.

Phone conversations with therapist discussing your child are billed in quarter hour increments starting after the first quarter hour.

Payment is due at the time of service, unless you have made other arrangements with our accounting office. We accept VISA, MasterCard or personal Checks.

I understand that health insurance policies and reimbursement are between myself and the health insurance company. That all services rendered by Myania Moses and Associates for the below referenced individual are charged directly to me, and I am personally responsible for payment in full to Myania Moses and Associates. I understand that if payment in full is not received by Myania Moses and Associates within ten days of invoice date that Myania Moses and Associates, will assess a five percent (5%) late charge on such outstanding balance. I understand that if my outstanding balance due to Myania Moses and Associates for the treatment of the above reference individual becomes Five hundred Dollars ($500) or more, Myania Moses and Associates reserves the right to withhold therapy up to and until such balance is paid in full. I understand that I will be responsible for all legal fees and collection fees with Myania Moses and Associates and may incur if payment is not made in accordance with the terms and conditions hereinabove. I understand that agreements regarding fee schedules and charges for canceled appointments are my responsibility and not the responsibility of my health insurance company, if any.

I____,acknowledge and accept full and complete responsibility for prompt payment of all services rendered to

____by Myania Moses and Associates, I acknowledge that prompt payment is due at time of treatment, unless I have made arrangements for monthly credit card billing. I have received written explanation of the fee schedule and the cancellation policy and I agree to both.

____ ____________________________

Signature of Parent/Guardian Date

Myania Moses & Associates Credit Card Authorization

This is not an online an online form, fill it out and bring to your appointment. Thank you!

Child's Name_______________________________________

We ask for 24 hours notice if you find you cannot make your appointment. Last minute cancellation (i.e.: less then twenty-four hours before the designated appointment) and/or no calls, no show will be billed for the treatment session missed and the invoice will reflect that information appropriately. Exceptions to the cancellation policy will be made for children who are ill upon awakening only if notice is received by 8 am. Therefore, please call and leave on your therapists' voice mail if your child is sick. If you wait until right before the appointment to call and cancel, you will be billed for the missed appointment.

By signing below you confirm that you fully understand that health insurance policies and reimbursement issues are between you and your health insurance company, that all services rendered to your child are charged directly to you and that you are personally responsible for payment to Myania Moses and Associates and this responsibility is not related to potential health insurance coverage or reimbursement.

The undersigned authorizes Myania Moses and Associates, to make the following charges to their credit card for payment of occupational therapy services and /or associated expenses.

CREDIT CARD NUMBER____

VISA or MASTERCARD ONLY

EXPIRATION DATE____

3 DIGIT CODE ____

NAME ON THE CARD ____

AS IT APPEARS ON THE CARD

SIGNATURE OF CARD HOLDER____

DATE____

ADDRESS THE CARD STATEMENTS ARE MAILED TO (BILLING ADRESS)

____

ZIP CODE ____

This information must match the card or it will not process. We request that you notify our office as soon as possible if any of this information changes. This agreement will remain in effect, and your card may be charged monthly, until this agreement is cancelled in writing.

CONSENT FORM
NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

This is not an online form. Please print the form, fill it out and bring it to your appointment. Thank you!

I have received, read and understand your Notice of Privacy Practices. I understand that Myania Moses and Associates has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at its office to obtain a current copy of the Notice for Private Practices.

I, ____, give my permission to Myania Moses and Associates to exchange information with the following physicians, programs or other persons:

____

____

____

about,____,
whose date of birth is________________________.

Patient Name ____
(Name Printed)

Relationship to Client ____

Signature ____

Date ____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices acknowledgment, but was unable to do so as documented below:

Date:__________Initials_________Reason______________________________________

Billing/Insurance Information

If you are planning on submitting to your insurance company for reimbursement, please fill out the following, so we can put the pertinent information on your monthly statement.

Child's name: Pediatrician:

Mother's name: Pediatrician's phone:

Father's name:

Address:

Home phone:

Mother's work phone: Father's work phone:

If you are submitting to insurance please be sure that we have a copy of the prescription on file.

Insurance company:

Insurance company phone number:

Insurance company address: Contact person:

Policy holder name: Policy number:

Please provide SS #'s only if needed

Policy holder:

Child:

Thank you for your cooperation Myania Moses and Associates