Valley Family Therapeutics, LLC
551 E. Station Avenue
Coopersburg, PA 18036
Office: (484) 863-9220 Fax: (610) 465-8611
Email: Valleyfamilytherapy@gmail.com

FINANCIAL AGREEMENT AND INSURANCE POLICY

A copy of driver's license and insurance information is required. Benefits will be verified upon receipt of you insurance information and you will be made aware of any estimated out-of-pocket expenses. Information obtained from insurance companies is not always a guarantee of payment. Families are ultimately responsible for payment for non-covered services. It is imperative that families are aware of their insurance coverage and their potential responsibilities. We will strive to keep open communication regarding insurance and payment. Clients will inform Valley Family Therapeutics, LLC of any changes regarding insurance. Client will assign benefits for filed claims to be paid to Valley Family Therapeutics, LLC. Any payment (s) sent directly to the family intended to cover therapy provided by Valley Family Therapeutics, LLC should be immediately forwarded to Valley Family Therapeutics, LLC office.

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Client/Guardian/POA initials

The usual and customary rate for services is billed to insurance. If we bill your insurance and you have a deductible, the full amount to your deductible will be billed to you. Valley Family Therapeutics, LLC reminds clients that they are responsible for all co-pays, coinsurance and deductible expense associated with each date of service. Valley Family Therapeutics, LLC accepts cash, credit/debit cards, & checks. There is a $30 fee for all checks returned from the bank for any reason. I request that payment of authorized medical benefits is made on my behalf directly to Valley Family Therapeutics, LLC, the provider of service furnished to my family. I authorize Valley Family Therapeutics, LLC to release any medical information to my health insurance and/or it legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance to HIPPA health information standards. I authorize payment of service (s), otherwise payable to me under the terms of my private, group employer's group health insurance plan, directly to Valley Family Therapeutics, LLC. I hereby authorize that photocopies of this form valid as the original.

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Client/Guardian/POA initials

Valley Family Therapeutics, LLC will submit claims to insurance within two weeks of service date. If payment has not been received within 60 days, the family will be responsible for balance. If insurance makes payment, the family will reimbursed any money that was paid for service. If a family received a bill that is not paid within 15 days of receipt of invoice, there will be a 5% fee accrued monthly on the remaining balance added to the account and services risk being put on hold.

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Client/Guardian/POA initials

CONSENT TO TREAT

I, _____consent for Valley Family Therapeutics, LLC to provide _____with PT/OT/ST services. I consent to care and treatment falling under the practice guidelines and the State of Pennsylvania, I acknowledge that is always a risk of injury with any therapy.

_____ **DATE**_____

Client/Guardian/POA SIGNATURE

PRINTED NAME_____