PAYMENT POLICY

Thank you for choosing Therapy InSync to serve your family. We are committed to providing you with the highest quality care. Please know that the timely payment of your bill is an integral part of our service; this payment policy is an agreement between you and Therapy InSync LLC for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family member. All clients are required to review and sign our payment policy.

All therapy fees (including session fees and/or co-pays, if applicable) are due at the time services are rendered.

We accept the following payment methods at this time: Cash, Check, Visa, Master Card, and Discover. **(**Checks should be made payable to "Therapy InSync LLC".). We will provide you with an invoice outlining the services rendered and the amount charged.

Please read AND initial the spaces, to acknowledge your understanding and then sign below:

_____ I understand and agree that I am responsible for all costs/fees that any third-party payer (ex. insurance company, private school, etc.) does not cover. I understand and agree that in the event that a third-party payer source determines that rendered therapy services are "not covered" or otherwise denied, that I may be responsible for all outstanding charges. I understand and agree that I will be billed accordingly and will be responsible for immediate payment. I understand that Therapy InSync LLC will not become involved in disputes between me and my third-party source regarding uncovered charges or reasons for denial.

_____ I understand and agree that if fees are not paid in full, treatment sessions may be postponed or cancelled until payment is received.

_____ I understand and agree that all returned checks will be subject to a $25.00 returned check fee. I understand and agree that charges incurred and not paid after 30 days may be turned over to a collection agency at my expense.

_____ I understand that I am responsible for all legal and collection fees, which Therapy InSync LLC may incur if payment is not made in accordance with the terms and conditions herein.

_____ I understand and agree that refunds will be issued *only* in instances of overpayment. I understand and agree that all refunds will be processed within 14 days after Therapy InSync is notified of such overpayment. Refunds for payments made with a credit card will be credited back to the credit card used. All other refunds will be issued by a check.

_____ I understand and agree that all cancellations require 24–hours' notice and that there will be a $25.00 charge for any cancellations made less than 24 hours in advance of the appointment. This charge is my sole responsibility and will not be covered by a third-party source.

[Signature page to follow]

I, _____, (parent/guardian name) understand the payment policy and the risks of not adhering to it.

_____ _____
Print Name of Child Child's Date of Birth

_____ _____
Signature of Guardian or Responsible Party Relationship to Client

704 N. Main St. Newcastle, OK, 73065
PHONE: (405) 432- 3193. FAX: (405) 432- 6023