



Financial Agreement & Payment Policy

Our Commitment

At Hand in Hand Therapy, we are committed to providing high-quality care in a transparent and respectful environment. This agreement outlines our financial and billing policies to help avoid misunderstandings and ensure smooth communication regarding payment.

Insurance Billing & Payment Responsibilities

We are happy to bill your insurance provider on your behalf. However:

- **You are responsible for all charges not covered** by your insurance, including deductibles, co-pays, co-insurance, or services not covered.
- **Verification of benefits** is not a guarantee of payment.
- It is your responsibility to understand your insurance plan, obtain any required referrals or authorizations, and notify us of any insurance changes.
- Any balance not paid by insurance within 60 days may be billed directly to you.

Private Pay Rates

For clients without insurance coverage or those choosing to pay out-of-pocket:

- **Evaluation:** \$175 per evaluation
- **Treatment Session (60 minutes):** \$125 per session
- **Other services (e.g., reports, consultations):** \$75 per hour

Payment is due at the time of service unless other arrangements have been made.

Attendance, Cancellations, and No-Shows

- We require **at least 24 hours notice** for cancellations.
- Cancellations made **less than 24 hours in advance** may result in a **\$50 late cancellation fee**, not billable to insurance.
- **No-shows** (missed appointments without notice) may be charged a **\$40 fee**.
- Repeated missed appointments may result in a pause or discontinuation of services.



Payment Methods Accepted

We accept:

- Cash
- Credit/Debit Cards
- Checks (returned checks may incur a \$30 fee)

Outstanding Balances

- Invoices are due upon receipt unless a payment plan is arranged.
- Accounts 30+ days past due may be subject to interest or collection efforts.
- Please speak with us early if you need a **payment plan or financial accommodation**. We're here to help.

Acknowledgment and Signature

I have read and understand the financial policy above. I agree to be responsible for payment of all services provided to my child by Hand in Hand Therapy, PLLC. I understand that I may ask questions or request a copy of this agreement at any time.

Child's Name: _____

Parent/Guardian Name: _____

Relationship to Child: _____

Signature: _____

Date: _____