106 East 25th Ave.
Covington, LA 70433
985-327-5352

Financial Policies

Our office will bill your insurance company as a courtesy on your behalf; however, you are financially responsible for all non-covered services. Theraplay Pediatrics will call your insurance company to verify your benefits. This is not a guarantee of payment. It your responsibility to know your coverage.

Please initial_____

Certain insurance plans will limit how many therapy sessions are allowed per year. It is your responsibility to know how many. If you exceed the visit limit, you are financially responsible for all services rendered. It is your responsibility to know how many visits your plan allows and if you exceed that number.

Please initial_____

Under your health plan, you are financially responsible for co-payments, co-insurance or deductibles for covered services. Co-pays and co-insurances are due to at the time of service.

Please initial_____

Theraplay Pediatrics accepts cash, credit cards, and checks. There is a $35 fee for any bounced check.

Please initial_____

Some insurance companies will send the payment directly to you. You agree to forward the check to Theraplay Pediatrics within 30 days of receipt.

Please initial_____

Please inform us of any changes made to your insurance. If you do not give us these changes in a timely manner, you are financially responsible for any balance.

Please initial_____

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For private pay, a 60-minute speech or occupational therapy session is offered at a standard rate. A discount of 50% will be applied if payment is made at the time of service. Theraplay Pediatrics reserves the right to adjust these rates at any time. Evaluations for speech or occupational therapy are also available at a standard rate, with a 50% discount for payment made at the time of service.

Please initial_____

You are financially responsible for any remaining balance, including amounts not covered or denied by your insurance.

Please initial_____

Invoices are emailed to the email address on file monthly. It is your responsibility to pay your invoice within 30 days. If you do not pay your outstanding invoice(s), Theraplay Pediatrics will charge your credit card in the amount of the outstanding invoice(s).

Please initial_____

I have read and agree to the terms above.

Parent/Guardian Signature: _____

Date: _____