FINANCIAL POLICY OF PENTATONIC THERAPIES, LLC

PENTATONIC THERAPIES FINDS THAT COMMUNICATION WITH OUR PATIENTS REGARDING OUR FINANCIAL POLICY ASSISTS US IN PROVIDING THE SERVICES TO YOU. THE FOLLOWING TERMS AND CONDITIONS ARE ACCEPTED BY PATIENT FOR SERVICES

DISCLAIMER:

Pentatonic Therapies will work to verify your existing private insurance benefits to see if music therapy services are covered. Music therapy may be billed using alternative billing codes that fall under existing rehabilitative and therapeutic benefits. Music therapy is considered Out of Network for all plans. In the state of Georgia, businesses have had success in billing with Aetna, Cigna, UHC, and other out of network benefits.

Medicaid does not cover music therapy services in the state of Georgia.

1. **INSURANCE:** Therapy services are provided directly to you, and not an insurance company. As a courtesy to its patients. Pentatonic Therapies, LLC will bill the Patient's insurance company. If the insurance has failed to pay we will expect (YOU to pay) the balance of your bill. If problems with the insurance arise it is the responsibility of the patient to establish communications with the insurance company. **(Patient's Initial) _____**

2. **AGREEMENT TO PAY:** I agree to pay for all services rendered. If a collection agency's services are required, I further agree to pay for all legal fees, court costs, reasonable attorney fees, and collection agency fees in connection to my debt. If my insurance does not provide benefits or provides a reduced benefit, I will be financially responsible to pay up to the agreed upon fee schedule. **(Patient's Initial) _____**

3. **CO-PAYMENTS:** It is the policy of Pentatonic Therapies, LLC to collect all applicable co-payments relating to HMO or PPO health care providers.

4. **DEDUCTIBLES:** It is the Patient's responsibility to pay for their applicable annual deductibles.

5. **SPECIAL NEEDS:** Special circumstances are understood to occur, and as a result it may be necessary to set up a payment plan for a patient requiring extensive treatment. If this becomes the case, please notify our office at the earliest opportunity.

PATIENT RESPONSIBILITY

I have read and understand the financial policy of Pentatonic Therapies, LLC. By signing this form, I consent to the above terms and conditions of treatment and understand that it is my responsibility for assuring that the financial obligation of services received is fulfilled.

I hereby authorize payment by my insurance carrier or other designated payer of medical benefits to Pentatonic Therapies. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. I also authorize Pentatonic Therapies, LLC to release to my insurance carrier or their agents any medical information about me needed to determine these benefits or the benefits payable for service.

Patient's Signature: _____ Date: _____

PERSONAL GUARANTOR FOR MINOR

(If the Patient is a minor under 18 years of age, a Responsible Party must complete the following)

I agree to the terms and conditions of this financial policy and personally guarantee to pay Pentatonic Therapies, LLC all costs incurred by the minor Patient.

Responsible Party: _____ Date: _____