Intervention Center For Early Childhood
Treating Special Needs with Special Care

FINANCIAL AGREEMENT

Patient Name:_____
Date of Birth:_____

ICEC, a non-profit pediatric therapy facility, dedicated to provide the very highest quality care and service to all of its patients.

ICEC will make every effort to ensure that you receive quality therapy which is medically necessary. However, please **be aware that your health plan makes the final determination regarding your care.**

ICEC will bill your insurance company for the services you receive. In the event that your insurance company denies payment for services as a result of, but not limited to, any reason or any reason listed below, you will be held financially responsible for the services provided.

Payment may be denied if your health plan determines:

- **The care given is not medically necessary**
- **The care given is a non-covered benefit**
- **The recipient is ineligible to receive the insurance benefit**
- **The therapy was not authorized**

Out-of-Network Financial Agreement

I understand that my Out-of-Network services may have co-insurance charges, higher co-payments, limited annual benefits and separate or higher deductibles. I also understand some Out-of-Network services require pre-certification from my insurance company in order to receive full benefits. Initial here ( )

Cancellation Policy

Appointments cancelled with less than a 24 hour notice are charged a $40.00 cancellation fee. Failure to contact the office prior to appointment time is a **no show** and will be charged $75.00. Initial here ( )

I have read the preceding information and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. If my insurance company denies coverage and/or payment for services rendered to me at ICEC, I assume the financial responsibility.

_____ _____
Date Patient/Parent/Legal Representative

I authorize the release of medical information necessary for filing health insurance claims for me by ICEC. I also authorize my insurance carrier to make payment directly to ICEC for services rendered.

_____ _____
Date Patient/Parent/Legal Representative