KINETIC KIDS, INCORPORATED
Occupational Therapy, Physical Therapy,
Speech Language Pathology and Consulting Services
2051 NW 112th Ave #125, Miami, FL 33172-1835
Phone: 305-878-0083 **Fax**: 305-477-7808
Email: awildac@kinetickidstherapy.com, jenniferg@kinetickidstherapy.com

Client Payment Policy

Thank you for choosing our practice! We are committed to the success of your therapeutic treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist or the Office Manager.

How May I Pay?
We accept payment by cash, check, VISA, MasterCard, and Discover.

Which Plans Do You Contract With?
Medicaid, United Healthcare, CMS, Humana, Amerigroup, Prestige, Wellcare, Staywell, Neighborhood, Sunshine, Blue Cross Blue Shield PPO, Cigna PPO, Aetna PPO and many other PPOs.

What is My Financial Responsibility for Services?
Your financial responsibility depends on a variety of factors, explained below.

Office Visits and Office Services

If You Have…	You Are Responsible For…	Our Staff Will…
Commercial Insurance Also known as indemnity, or "regular" insurance, or "80%/20% coverage." *Please note percentages may vary depending on your plan. Coverage for specific therapies may vary according to your plan.	Payment of the client responsibility for all office visits, and other charges at the time of office visit. This may include payment toward the deductible, copays, and non-covered services.	Call your insurance company ahead of time to determine deductibles and coinsurance. File an insurance claim as a courtesy to you, but you may be required to submit your own claims if requested.
HMO & PPO plans with which we have a contract	If the service you receive is covered by the plan: Copays and payments towards deductibles are requested at the time of the office visit if applicable. If the service you receive is not covered by the plan: Payment in full is requested at the time of the visit.	Call your insurance company ahead of time to determine copays, deductibles, and non-covered services for you. File an insurance claim on your behalf.
HMO plan with which we are not contracted.	Payment in full for office visits and other charges at the time of office visit.	Provide the necessary information for you to complete and file your claim directly with the insurance company. *Please note unless you have made special arrangements with your HMO insurance plan to utilize an out of network provider,claims submitted are often denied.
Point of Service Plan or Out of	Payment of the client responsibility	Call your insurance company ahead

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Network PPO	for all office visits, and other charges at the time of the visit. This may include payment toward the deductible, copays, and non-covered services.	of time to determine out of network benefits, copays, deductibles, coinsurance, non-covered and covered services for you. File an insurance claim as a courtesy to you but you may be required to submit your own claims if requested.
No insurance	Payment in full at the time of visits and other charges if applicable at the time of office visit.	Work with you to settle your account. Please ask to speak with our staff if you need assistance.

A parent or legal guardian must accompany clients who are minors on the client's first visit. This accompanying adult is responsible for payment of the account, according to these policies

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Kinetic Kids, Inc.

I authorize Kinetic Kids, Inc to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Date Signature Printed Name

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Pre-Authorized Use of Credit Card

I authorize Kinetic Kids, Inc to keep my signature on file and to charge my Visa/ MasterCard/ Discover for:

- ☐ Balance of charges not paid by insurance within 90 days and not to exceed $_____ for:
- ☐ This visit only
- ☐ All visits this year
- ☐ Recurring charges (on-going treatments or payment plan) of $ _____
  - Every _____ from _____ to _____
    (Frequency) (Date) (Date)

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the healthcare provider.

Client Name

Cardholder Name

Cardholder Address

City State Zip

Credit Card Account Number Expiration Date

Cardholder Signature Date