

Patient Information Form

Provider Name: _____

Address: _____

Phone #: _____

Fax #: _____

NPI: _____

Name: _____

DOB: _____

SSN: _____

_____ Male

_____ Female

Parent/Guardian Names: _____

Address: _____

Phone Number: _____

Cell Phone Number: _____

E-mail: _____ Please circle preferred method of communication.

Diagnosis (Please include ICD-9 Code if known): _____

Primary Physician: _____

Physician's Phone and Address: _____

Referring Physician (if different): _____

Insurance Information:

Primary Insurance: _____ Name of Insured: _____

Insured SS #: _____ Insured Date of Birth: _____

Employer: _____ Employer Address: _____

Member ID: _____ Group # _____ Effective Date: _____

Claims Address (found on back of card): _____ Cust Service #: _____

Secondary Insurance: _____ Name of Insured: _____

Member ID: _____ Group #: _____

Claims Address (found on back of card): _____ Cust Service #: _____

Medicaid Number: _____ Effective Date: _____

Signature: _____

Date: _____

Medical Insurance Billing Services

225 Sterling Brook Lane, Canton, GA 30114

Phone: 678-398-9919 Cell: 678-977-0697

Fax: 678-398-4183

Maureen.moir.dorsey@gmail.com



1180 Rosewood Drive Alpharetta, GA 30005
 Ph: 770-886-6800 Fax: 770-886-8617
 5955 State Bridge Road Suite 110 Johns Creek, GA 30097
 Ph: 678-749-7600 Fax: 770-886-8617
www.ParallelPlaykids.net

“Parallel Play, Inc is an affiliate of Mind and Motion Management”

Financial Policy Regarding Payment of Services/Assignment of Benefits

Parallel Play, Inc accepts most forms of private health insurance, Medicaid and Medicaid CMOs. We are an in-network provider for Blue Cross Blue Shield PPO for OT services only. We are an out-of-network provider to all other carriers at this time.

Insurance verification: It is ultimately the responsibility of the patient to determine insurance coverage and payment for services rendered. To verify benefits, we need the following documentation **at least 1 DAY PRIOR to your first appointment:**

- **Patient Information Form** completed and faxed to our office *at least 1 DAY prior to first appointment*. If intake form not received prior to appointment you will be required to pay for services in full at time of service.
- **Financial Policy/Assignment of Benefits Form** signed by responsible party
- **Prescription** from your pediatrician with patient diagnosis--This is required to receive services and to have services paid for by your insurance carrier. *If no prescription provided, you must pay in full at time of service.*
- **Photocopy of Insurance Card**, copied front & back

Payment policies:

- **Billing Insurance Carriers is a Courtesy to our families.** Any unpaid balances/claims, not paid by your carrier are the responsibility of the family. Families are encouraged to determine benefit coverage and eligibility prior to receiving therapy and to track therapy sessions and payments made by their insurance carrier on the family's behalf. Any unpaid balance from insurance carrier is due within 30 days of the date listed on the Explanation of Benefits (EOB) which is mailed to the family directly from the insurance carrier.
- **All deductibles and co-payments are due at time of service.** If your payment exceeds your required deductible, Parallel Play will promptly submit a refund to the family. If you are receiving services at SEGA (Morton Road gymnasium), please complete the Credit Card authorization form. Your receipt will be mailed to you the following week. If paying by check, please submit to your therapist.
- **\$30 of co-insurance is due at time of service.** The balance will be billed at month's end. Again, if we are unable to obtain this information *prior to your first appointment*, services are due in full on date of service.
- **Economic Hardship:** As a courtesy, we may balance bill the remaining amount at a negotiated rate, as determined prior to therapy. **Failure to pay on the due date of your invoice** will forfeit the discounted rate and you will be responsible for the full balance.
- **Assignment of benefits:** All patients who receive reimbursement from their insurance providers must forward payment to Parallel Play, Inc. immediately. **Failure to forward payment within 30 days** will result in notification to your insurance provider and placement to our collection attorney.

Payment Responsibility: I hereby authorize Parallel Play, Inc to contact my insurance provider to verify coverage and to bill my insurance provider for reimbursement of therapy services rendered to my child, solely as a courtesy to myself. If my insurance carrier does provide coverage, I authorize payment for services to be directly assigned to Parallel Play, Inc. If I do not have insurance, or want to pay privately, payments are due in full, at the time of service. I understand that I am financially responsible for charges not covered by my insurance company, including deductibles, co-insurance and non-covered services. If I have Medicaid as primary or secondary insurance, it will be billed accordingly. If my insurance plan provides payment directly to me and not to Parallel Play Inc, I am responsible to submit payment for therapy services within 30 days. Although we will make every effort in applying for payment through your insurance carrier, it is your responsibility to ensure payments are rendered for services provided. I understand my credit card will be charged for any outstanding balance not paid by my insurance company within 90 days of service.

Fees for Occupational Therapy and Speech Therapy Services:

- \$200 per one hour treatment session
- \$300 per initial evaluation
- \$250 per re-evaluation

Discounts will be applied for patients paying on the date of service, to avoid processing time and administrative fees.

Payment Options: We accept cash, checks and credit cards. All payments are due within 30 days of invoice date to avoid disruption of service. If disruption of service occurs, rescheduling of therapy will be dependent upon current availability.

Cancellations: Please give 24 hour notice to cancel therapy. 3 missed sessions in a row, may result in your time slot being given to the next child on a waiting list. A cancellation fee of \$35 may be applied if 24 hour notice is not given.

Thank you for carefully reading this financial policy regarding payment of services and assignment of benefits. If you have any questions regarding this policy, please feel free to contact us at 678-749-7600 X 3. Your signature below indicates that you have read, understood and agree with this policy.

 Printed Name of Parent/Guardian

 Child's Name

 Signature of Parent/Guardian

 Date



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Ph: 770-886-6800 Fax: 770-886-8617
5955 State Bridge Road #110 Johns Creek, GA 30097
Ph: 678-749-7600 Fax: 770-886-8617

Type of card: Visa ___ Mastercard ___ Amount of payment _____

For services rendered: OT _____ ST _____

Date (s) of service: _____

Card number: _____ expiration date: _____

Name on Card: _____

Telephone #: _____

Zip code: _____

Signature of Cardholder: _____



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Medicaid Verification

Medicaid only allows for 2 times a month therapy without prior approval (PA). In order to obtain PA, we will need the following:

1. Current evaluation so that we can write a letter of medical necessity (LOMN). **We can provide for you.**
2. Prescription from your doctor stating specifically: OT (or ST) evaluate and treat, 1-2 times per week, 60 minutes per session, with re-assessment in 6 months. Diagnosis must be included. **We can obtain for you, with your permission to call physician.**
3. Notes from any therapies for the last 3 months.
4. IEP or IFSP 5. If child is home-schooled, or does not have an IEP or IFSP, must provide signed letter stating why child does not have an IEP/IFSP.