3331 Henry Road Anniston, AL 36207
(Phone) 256.624.6377 (Fax) 256.624.6376

FINANCIAL POLICY

As a courtesy, Grow Pediatric Therapy verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received.

It is the policy of Grow Pediatric Therapy that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. The office staff will explain this information to you prior to your first visit. At the conclusion of your visits with us you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly. Any unpaid balances may be referred to a collection agency at 33% collection costs, you will be responsible for any collection costs related to your account.

If you are covered by health insurance with therapy benefits, we will be happy to bill your insurance. Please provide your insurance information to the front office staff and we will verify your coverage as a courtesy. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.

We highly recommend that you also contact your insurance carrier and check into your coverage for therapy benefits. Do not assume that you will not owe anything if you have more than one insurance policy.

Responsible Party Name: _____

Responsible Party Signature: _____ Date: _____