



Financial Responsibility Statement

I hereby request and authorize the receipt of the medical item(s) or service(s) listed below for:

| NAME | AGE |
|-------|-------|
| _____ | _____ |
| _____ | _____ |

I give my consent to any appropriate and medically necessary procedures, medications, services or therapies that would be included in the treatment plan as required by the attending physician or supervised staff for myself or the above named person(s).

I understand and acknowledge that I am financially responsible for all charges incurred in the treatment plan, whether or not paid by insurance, rendered for the above named person(s).

We will bill your primary insurance as a courtesy to you.

- We assume payment of insurance benefits is not forthcoming on charges older than 60 days.
- Charges outstanding for more than 60 days will be **due in full** from you regardless of the type of insurance involved.
- Any remaining balance after your co-pay and you primary coverage has been paid, including items classified as "above usual and customary," is due from you upon receipt of the explanation of benefits from your primary insurance carrier. **You will be responsible for any item not paid in full by your insurance benefits.**
- While we will take reasonable action to provide accurate therapy benefit information for your specific plan, be aware that verification of benefits is **not a guarantee of payment from your insurance carrier.**
- Secondary insurance will be your responsibility to file and collect.

A Step Ahead Pediatric Therapy provides marketing material and other compensatory gifts to our referral sources which include, but are not limited to, our northern Kentucky pediatric offices and other agencies.

| Office Use |
|--|
| Description of Medical Items or Services: _____ _____ _____ |
| Insurance Verification: Therapy covered? _____ Deductible? _____ Met? _____ Co-Pay? _____ Co-Insurance? _____ Visit Limit? _____ Pre-Authorization or Pre-Certification required? _____ |
| Additional Information _____ _____ |

This is only an estimation of benefits from your insurance company and not a guarantee of payment. All benefits are subject to review at the time services are rendered.

Signature: _____ Date: _____

Relationship to patient: _____