the WAVERLY GROUP
Collaborative Pediatric Assessment and Therapies

Financial & Cancellation Policies

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial & insurance policies.

Financial Policy

1. We accept Visa, MasterCard, Discover, debit cards, HSA cards, cash and checks. Payment can be made in the form of your preference, however **we require a valid credit card on file** to pay your charges in the event that your balance remains unpaid for a period of more than 30 days. While a credit card on file is mandatory, you have the option of how you would like to pay when you receive your invoice. The default option is to charge your card on file unless other arrangements have been made.

2. Payment for all services is due at the time of service unless arrangements have been made in advance, except for evaluations or screenings performed by our psychologists, speech therapists, occupational therapists and physical therapists. Those require **50% of payment prior to the start of testing and the balance is due at the time of the last testing session, prior to release of the written report.**

3. If your check is returned by your bank, for any reason, you will be charged a fee of $25.00.

Cancellation Policy

You are obligated to pay for late cancellation fee/no show fee as outlined below.

We will provide you with an email address for each of your service providers, you **must** communicate any notice of cancellation by email to your service provider.

Cancellations with more than 24 hrs. notice of an appointment: **No Charge**

Cancellations within 24hrs. of an appointment: **30% of Total Session(s) Fee Charged**

Cancellation at time of appointment with no notice: **Full Fee Charged**

Patients in our intensive program or who have full time dedicated staff, such as school shadows, please see our separate Cancellation Policy.

Once you have paid the required cancellation fee, you **MAY** be offered a make-up session. This make-up session will be billed to you less the cancellation fee you have paid. The make-up session is contingent on whether or not scheduling allows for it, and must be within 30 days of the cancelled session. Please note that the offered session may not be with your usual service provider but with another available, qualified service provider.

If you cancel three or more sessions in any given 45 day period for any reason, you may lose your regularly scheduled appointment time and day.

I have read and understood The Waverly Group, LLC Financial and Cancellation Policies and I agree to be bound by their terms. I also understand that such terms may be amended by the practice from time to time.

Patient /Guardian Signature _____ Date

INSURANCE INFORMATION AND PATIENT RESPONSIBILITIES:

The Waverly Group does NOT accept insurance

The Waverly Group is out of network with all carriers

The Waverly Group will:

1. *Give you a paid bill to submit to your insurance company so that you can attempt to get reimbursed in part or in full under your out of Network Insurance coverage if you have it.*
2. *With your permission, we will cooperate fully with your insurance company if they request copies of treatment notes or other information related to the processing of your claim. Please note that we cannot make any representation that your insurance company will reimburse you in part or in full for our services, and payment to us in full is required regardless of the final determination of coverage by your carrier.*
3. *We will assist you with authorizations, however, we are not responsible for following up and keeping track of expiration dates of authorizations or approvals.*
4. *We will provide you with copies of any submissions we make to your carrier to facilitate your follow up.*

Patient Responsibilities:

1. You must determine whether or not your carrier requires any pre-authorizations or approvals to guarantee out of network coverage. If you do not obtain the pre-authorization or approvals as required by your carrier, you remain responsible for the cost of any and all services.
2. You must obtain a letter of medical necessity from your physician if one is required by your carrier.
3. You must inform us of any diagnosis which has been given to your child prior to your engaging services with us.
4. You must keep track of any session or time limits on approvals that have been granted and reapply in a timely manner.
5. You must follow up on all submissions to your insurance carrier, including any that we make on your behalf to the carrier or their agents and notify us promptly of any further requests from them .
6. You must review our invoices within 45 days of the invoice date and notify us immediately of any changes, discrepancies or problems. After 45 days of the invoice date, any requests for correction, amendment, etc., will result in a fee for the service of $20.00 per hour to you for any time spent in excess of one hour.

I HAVE READ AND UNDERSTOOD THE WAVERLY GROUP, LLC INSURANCE POLICY AND I AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND THAT SUCH TERMS MAY BE AMENDED BY THE PRACTICE FROM TIME TO TIME.

Patient /Guardian Signature _____ Date

Credit Card Payment Authorization Form

Sign and complete this form to authorize The Waverly Group, LLC to make a debit to your credit card listed below. By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date. You also agree to notify us 30 days in advance if the credit card is due to expire, or if it is no longer an active card. **An active card must be kept on file at all times.**

The below credit card will be charged for all services rendered. You will be sent a copy of the paid invoice by email to the address provided by you below.

Please complete the information below:

I _____ authorize The Waverly Group, LLC to charge my credit card
(full name)

account indicated below for all services on or after _____.

This payment is for any and all services performed by The Waverly Group.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV2 (3 digit number on back of Visa/MC) _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated above .