KIDS THRIVE THERAPY, LLC

Statement of Patient Responsibility
UPDATED 4-15-2025

Patient Name: _____ DOB: _____

General Policy

Kids Thrive Therapy, LLC (KTT) appreciates the confidence you have shown in choosing us to provide for your healthcare needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment of our fees in full. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf for the plans in which we are a participating provider. However, you are ultimately responsible for the payment of your bill.

You hereby certify that you have medical insurance, that the information you have provided regarding your medical insurance coverage is correct, and that you are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you elect to continue past your approved period, you will be responsible for your balance in full. Any balances over 90 days old will incur a monthly interest charge of 1.5%.

Consent for Treatment, Authorization to Release Information, and Communication Mechanisms

You hereby authorize KTT, through its appropriate personnel, to perform or have performed appropriate assessment and treatment procedures on you or the above-named patient. You further authorize KTT to release to appropriate agencies any information acquired in the course of your or the above-named patient's examination and treatment. You authorize KTT to communicate with you via text, email, or over the telephone. SMS opt-in and phone numbers collected for SMS communication purposes will not be shared with any third party and affiliates for marketing purposes.

I have read and understand all of the above policies regarding my financial responsibility to Kids Thrive Therapy, LLC, for providing services to the above-named patient or me, and I agree to the terms described. I authorize my insurance provider to pay any benefits directly to Kids Thrive Therapy, LLC, the full and entire amount of the bill incurred by me or the above-named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient/Guarantor/Parent/Guardian Signature _____
Date_____

Additional Policy for Self-Pay Patients (if applicable)

I do not have health insurance, or Kids Thrive Therapy, LLC, does not participate with my insurance carrier. Thus, I will be responsible for services rendered by Kids Thrive Therapy, LLC. I agree to pay Kids Thrive Therapy, LLC the full and entire cost of the treatment provided to me or the above-named patient at each visit.

Patient/Guarantor/Parent/Guardian Signature _____
Date_____