

570 West Crossville Road, Unit # 104• GA 30075

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**Insurance/Payment Agreement**

Attention Parents:

We are delighted that you have chosen Bright Horizons Pediatric Therapy, LLC for your child’s therapy needs. We care about providing services to all children in need and would like to help you in any way we can; therefore it is important that you please make sure that all of your medical benefits are accurate and up to date.

We will be responsible for verifying your benefits; however information that is obtained from insurance companies is not always a guarantee of payment. Some insurance policies require your deductible to be met before your provider agrees to make payments. ***Co-pays may also be required; therefore you as the policy holder are responsible for paying any deductibles and/or co-pays that apply.******If your insurance provider denies any claims, you will be responsible for payment of these services. If you fail to make payments, your child’s therapy will be put on hold until your account is paid in full.***

Please provide a copy of the front and back of your insurance card and a copy of your driver’s license. You can fax or mail a copy of your information so we can check your benefits as quickly as possible. ***If there is ever a change in your insurance provider or a renewal with your current insurance provider, it is your responsibility to provide us with the information as soon as possible.*** We will always put forth our best effort to work with you and your insurance carrier to ensure your child remains eligible for their services.

If your insurance is not being used as a method of payment and you are paying out of pocket for your child’s evaluation and/or therapy sessions, ***your are responsible to pay the full amount on the date of service.*** ***If you do not pay the full amount on the date of service Bright Horizons Pediatric Therapy, LLC has the right to dismiss your child from their speech and language services at any time.***

***I have read the above information and agree to abide by Bright Horizons Pediatric Therapy, LLC insurance/payment agreement and accept all terms and conditions.***

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Child’s Name Insurance Provider’s Name

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Parent or Guardian’s Name Date

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Parent or Guardian’s Signature