4483-A Forbes Blvd, Lanham, MD 20706 or 1526 Howard Rd, SE Washington, DC 20020*Phone: 240-479-6769 * Fax: 1888-242-8040

NOTIFICATION OF PATIENT RESPONSIBILITY

We require a 24 hour notice of cancellation. If in the event of an emergency occurs after hours, please leave a message on the answering machine.

Your insurance policy requires you to make a payment of your co-payment and deductible/co-insurance at the time of service. In accordance with your insurance company, *Paradigm Therapy Partners* will collect your co-payment, unmet deductible amount, and/or co-insurance prior to services being rendered. Not adhering to these terms could be a violation of our contract with your insurance company and risk not being reimbursed for your treatment process.

"Paradigm Therapy Partners verifies benefits as courtesy to you. However, Paradigm Therapy Partners does not accept responsibility for any incorrect information given by your insurance carrier regarding your co-pay/co-insurance benefits or benefit plans."

If co-insurance responsibility has been established we may ask that you make small payments towards the ending balance. This is NOT intended to release/relieve or negate you from the responsibility of the final balance due. Based on that information your insurance company provided us, the ESTIMATED amount that you are responsible for is listed below.

Co-Payments: $__________________________________ per visit

Co-Insurance: ____________________________________ per visit

Deductible Amount: $______________________________ per benefit period

Deductible Amount still to meet $ ___________________________________

We reiterate again, "Paradigm Therapy Partners verifies benefits as a courtesy to you. However, Paradigm Therapy, does not accept responsibility for any incorrect information given by your insurance carrier regarding your co-pay/co-insurance benefits or benefit plans."

- Our Front Office staff can accept payment from you in the form of credit card, check or cash. As a courtesy, we will bill your insurance company for their portion of the bill.
- There will be a $50.00 cancellation/no show fee for all appointments that are not rescheduled or cancelled within 24 hours. Fees are due at your next scheduled appointment. Your insurance company does not cover these fees.

Please verify that you understand your financial responsibility by signing and dating this form and let us know if we can assist you in any other way.

____________________________________ ___________________________

Patient/Legal Guardian Signature Date