Therapy Yoga Gymnastics Rocks LLC (TYGR)

Conditions Contract

PLEASE SIGN AND RETURN.

Prior to beginning services, please provide our office with

- **TYGR Registration Sheet**
- **Conditions Contract (this)**
- **Physician Prescription for Occupational, Physical, or Speech Therapy with diagnosis code. We rely on you to maintain a current prescription with a valid diagnosis that covers all dates of service.**
- **Copy of insurance card front and back**

Therapy Services and Costs.

Occupational Therapy	**$160 / hour (4 Units)**
Physical Therapy	**$160 / hour (4 Units)**
Speech Therapy	**$125/ Per Session (45 Minutes)**
Group Therapy	**$120 / hour (4 Units)**
Consultation and support	**$30 / 15 minutes**

Ongoing Therapy is charged in 15 minute Units. A typical session is 1 hour in duration, 4 Units. This includes 53 – 55 minutes of direct therapy and 5 – 7 minutes for transition, consultation, and support before leaving the gym.

Consultation and support work covers tasks additional to therapy sessions to enable TYGR therapists to best treat your child. These may include tasks such as reviewing medical records, interface and support time additional to Therapy Sessions, and any specific additional work requested. I understand that these tasks are not eligible for insurance payments and will be charged directly to me.

Insurance

Insurance verification. I understand I assume the responsibility to determine insurance coverage and payment for services rendered. I understand I am responsible for arranging authorization prior to the start of treatment. TYGR will assist in submitting insurance claims as a courtesy.

I understand I am responsible for updating and obtaining all necessary medical and insurance authorizations for Occupational, Physical and Speech Therapy services, prior to service date and ongoing.

Non insurance

If I do not have insurance, or want to pay privately, payments are due in full at the time of service.

Payment responsibility

I hereby authorize TYGR to contact my insurance provider for reimbursement of therapy services rendered to my child, solely as a courtesy to myself. If my insurance carrier does provide coverage, I authorize payment for services to be directly assigned to TYGR.

I understand that I am financially responsible for charges not covered by my insurance company, including deductibles, coinsurance and non-covered services. If my insurance plan provides payment directly to me and not to TYGR, I am responsible to turn over payment for therapy services immediately. TYGR will assist in applying for payment through insurance, but it is my responsibility to ensure payments are rendered for services provided. An invoice and statement will be sent each month.

info@therapygymnastics.com
fax: 773-572-4886

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I am liable for all costs not met by insurance.

Co-payments are due at the time of service.

Unpaid balance from my insurance is due within 30 days of the date listed on the Explanation of Benefits.

I authorize registration of my credit card with TYGR to enable payment of monthly balances due.

Overdue amounts

I understand that invoices left unpaid for a period exceeding 21 days will incur an additional $15.00 Late Payment Charge per month. If 21 more days elapse without payment, the account will be sent for collection, unless other arrangements have been made, and I will be responsible for any legal and collection agency fees incurred.

Session Cancellation policy

I understand TYGR will honor all cancellations received and confirmed a minimum of 4 hours prior to the scheduled session. I agree to pay a $50 cancellation fee if 4 hours notice is not given.

Photography

I permit TYGR to photograph or video any session of my child and use these materials to advertise TYGR operations and objectives. I accept that material may be used on television or radio, in print and on the TYGR website and Twitter feed.

Authorization for information exchange

I permit and consent as parent or legal guardian for TYGR to release and or receive information with other healthcare providers and educators regarding my child.

Credit Card Automated Payment.

Card Number:_____ Expiry Date: _____

Cardholder Name:_____ Visa ☐ Mastercard ☐

I authorize TYGR to make recurring charges to this card for Therapy Services.

I have read, understood, and agreed with the information in this document.
I have read or received a copy of TYGR's HIPAA Privacy statement.

Signed _____ Date _____

Payment.

If you maintain health insurance, part of your therapy expenses may be covered. TYGR asks that you register a credit card to enable payment of your account balance. You will be notified of the invoice balance and payment date each month.

PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSEMENT FOR FEES DUE TO THE PROVIDER, NOT A FORM OF PAYMENT.

Signed _____ Date _____

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