



561 E Mitchell Hammock Rd, #400
 Oviedo, FL 32765
 407-810-2225 (O) 800-497-1372 (F)

PAYMENT POLICY

Patient Information:

Name (Last, First)	Age	Date of Birth	Sex M F
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Responsible Party/Guarantor:

Name (Last, First)		Age	Date of Birth	SSN#
Address		City	State	Zip Code
Marital Status S M D				
Home Phone	Cell Phone	Work Phone	Email	

Payment Information/Pay Source:

Select One:

- Private Insurance
- Medicaid
- Early Intervention (birth – 3yrs)
- Self Pay/Private Pay

Insurance/Medicaid Information

Insurance Company	Primary Policy Holder Name	Date of Birth	Relationship to Patient
Policy # or Medicaid #	Group #	Employer	Ins. Phone #

Patient’s Primary Care Physician/Pediatrician

Name (Last, First)	Phone	Fax
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Chapman & Associates Therapy Solutions, LLC will file therapy service claims with your primary medical insurance as a courtesy to our patients. However, it is the responsibility of the patient or legal guardian for payment in full if your therapy services claims are denied by your insurance for any reason. In the event your insurance denies services, it is the patient’s or legal guardian’s responsibility for payment in full to Chapman & Associates Therapy Solutions, LLC. Patient or legal guardian is also responsible for all co-payment, co-insurance and deductible as defined by your insurance policy.

Patient/Guarantor will be charged a fee of \$25 for therapy cancellations (within 24 hours), missed visits and returned checks.

The undersigned hereby agrees to the above mentioned policies.

Signature of insured or authorized person	Date
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