



Agreement to Utilize Insurance/Third-Party Payor

(revised as of 1-1-2023)

Peak Potential Therapy LLC (PPT) is pleased to provide you with this information to help you understand our client billing procedures. It is important that you are aware of your financial responsibilities. On behalf of the client, the parent or client's legal representative recognizes, understands, and consents to the following:

Financial Responsibility: Subject to applicable law and the terms and conditions of any applicable contract between PPT and a third-party payor, and in consideration of all health care services rendered or about to be rendered to the client, I agree to be financially responsible and obligated to pay PPT for any balance not paid under the "Assignment of Benefits/Third-party Payors" paragraph below.

Assignment of Benefits/Third-Party Payors: In consideration of all health care services rendered or about to be rendered to the client, I hereby assign to PPT all right, title, and interest in and to any third-party benefits due from any and all responsible third-party payors of an amount not exceeding PPT's regular and customary charges for the health care services rendered. I authorize such payments from applicable third-party payors. A list of usual and customary charges, "Fee Schedule", is available upon request, and can be viewed online at PeakPotentialTherapy.com. I consent to any request for review or appeal by PPT to challenge a determination of benefits made by a third-party payor. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by a third-party payor. In consideration of PPT's services received or to be received for medical and or educational services, I assign to PPT all benefits herein specified, not to exceed the PPT charges. I direct third-party payor to pay such benefits directly to PPT. I hereby agree to pay any and all PPT fees that exceed or that are not covered by my third-party coverage including services and waive any and all notices and demands in the event of non-payment.

Payment for Non-Reimbursable Items & Billing Information: I understand and agree to pay the charges incurred by me or the client for materials and or services, and hereby authorize PPT to bill me or an applicable party for such use and I agree to pay or otherwise arrange for and ensure payment of the same. I am aware that my billing statement will show charges for services that are in two categories, billable therapeutic services that are covered by the third-party and non-billable services that are not covered. This is regardless of the type of third-party. For additional questions, contact Natalie "Holly" Reimann 330-405-8776. If the third-party does not cover the remaining balance, or if I do not have a third-party payor, the balance will be billed to me.

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Payment/Notice of Privacy Practices/Certification: I certify that to the best of my knowledge and belief, the information provided is complete and correct. I authorize any holder of medical or other information about me or the client to release to the third-party, its intermediaries or carriers of any information needed for a related claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to Peak Potential Therapy furnishing services. I understand that this consent is subject to revocation by me at any time in writing, except if the person or entity authorized to make a disclosure has already acted in reliance on this form. Otherwise, subject to applicable law, this consent will expire at the same time PPT's record retention period for this document expires.

Additional Permitted Uses and Disclosures of Confidential Medical Information: I consent to the release of my and the client's health information and financial account information to all third-party payors and or their agents that are identified by PPT, its billing agents, collection agents, attorneys, consultants, and or other agents that represent PPT or provide assistance to PPT for the purposes of securing payment from all parties who are potentially liable for payment for the client's health care. I can revoke my consent in writing at any time except the extent that PPT has already relied on my consent. I understand and consent to disclosure of confidential medical and or educational information to a State or Federal Health Oversight Agency; an appropriate Public Health Authority; for purposes required by State and or Federal law; in cooperation with a Law Enforcement Investigation; in cooperation with a domestic or child abuse investigation; and for any other permissible purpose as outlined in Notice of Privacy Practices.

Acknowledgments (Please circle the appropriate response):

1. I hereby agree to be liable for and pay Peak Potential Therapy LLC the difference between the established PPT rate for the payment rate provided by third-party.
YES NO N/A
2. I acknowledge that I received of a copy of Peak Potential Therapy LLC's Policies, which include the "Notice of Privacy Practices".
YES NO

If "no", reason acknowledgement of Policies not received: _____

I am or about to be the client or authorized to sign this document. I have read all the above and understand its terms.

Printed Client Name

Date

Printed Parent Name

Signature of Parent, if client is a minor

Pediatric Therapy Services with a Developmental & Holistic Approach to Treating Children with Disabilities