

35105 Kenai Spur Highway Ste. A • Soldotna, Alaska 99669 • Phone: 907-260-7444 • Fax: 866-829-0999

CANCELLATION – FINANCIAL POLICY

Child's Name:	
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This is an acknowledgement of our policies; even if not applicable to your situation.

Please initial, in the spaces below, that you have read each policy.

_____ **LATE CANCELLATION FEE:** Please call a *minimum of 24 hours in advance* to cancel an appointment. A *\$10.00 fee* for cancellations *received after 7:30 am* is due before the next scheduled appointment.

_____ **LATE ARRIVAL FEE:** Late appointment arrivals of 10 minutes or more will be charged a *\$10.00 late fee* which is due before the next scheduled appointment.

_____ **LATE PICKUP FEE:** Please be a minimum of 5 minutes early to pick up your child. A late pickup fee of *\$10.00 for the first 10 minutes, plus \$1.00 for each additional minute*, is due before the next scheduled appointment.

_____ **NO SHOW FEE:** If a child misses a scheduled appointment without prior notification this will be counted as a no-show. A *\$20.00 no-show fee* is due prior to the next scheduled appointment. Your child will be placed on hold after two consecutive no-shows. If the issue is not resolved within one week your child will be placed on the wait list or discharged.

_____ **WAIT LIST:** Your child will be placed on the wait list if *monthly attendance drops below 75%*. Exceptions are extended periods (under 3 weeks) with advanced notification, i.e. vacation, physician trips, or other approved extenuating circumstances.

_____ **AGREEMENT TO PAY:** You will be fully responsible for all services not covered by your insurance or determined as not medically necessary. It is your responsibility to contact your insurance company to see if you are eligible for services. I understand and agree to be financially responsible.

_____ **DEDUCTIBLES/CO-PAYS:** If your insurance determines you have not met your deductible, or if you have a co-pay, you will be fully responsible for payment in a timely manner.

_____ **COLLECTIONS:** We will send you to collections if we do not receive *payment in full within 90 days after receiving billing invoice from us*.

_____ **DISAGREEMENTS WITH INSURANCE:** We will file insurance as a courtesy to you, but *we will NOT contest with your insurance company*. You are responsible for handling any disagreements you have with your insurance provider.

I hereby understand the above financial/cancellation policy and agree to abide by it.

Parent/Legal Guardian Signature:		Date:	
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