



Child's Name: _____ Date of Birth: _____

Please know that the timely payment of your bill is an integral part of our service and as such, this payment policy is an agreement between you and Bloom Pediatric Therapy, Inc. for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family member. As a client of Bloom Pediatric Therapy, you are required to carefully review and sign our payment policy.

All therapy fees (including session fees and/or co-pays, if applicable) are due at the time of service.

We accept the following payment methods at this time: Cash, Check, Credit/Debit, and Health Savings Account. *(Checks should be made payable to: Bloom Pediatric Therapy, Inc)*

Please read to acknowledge understanding and then sign below:

- I understand that I am responsible for all costs / fees that any third-party payer (ex. insurance company, private school, etc.) does not cover. In the event that a third-party payer source determines that rendered therapy services are “not covered” or otherwise denied, I will be responsible for all outstanding charges. I understand that I will be billed accordingly and will be responsible for immediate payment. I also understand that Bloom Pediatric Therapy will not become involved in disputes between you and your third-part source regarding uncovered charges or reasons for denial.
- I understand that if fees are not paid in full, treatment sessions may be postponed or cancelled until payment is received.
- I understand that I am responsible for all legal and collection fees, which Bloom Pediatric Therapy may incur if payment is not made in accordance with the terms and conditions herein.

I, _____, *(name of parent/legal representative)*
understand the payment policy and the risks of not adhering to it.

Print Name of Child

Signature of Parent/Guardian/Responsible Party

_____ Date _____ Relationship to Child