# Key To Recovery Therapy Services, Inc.

7700 Old Branch Avenue Suite E-108 Clinton, Maryland 20735
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EMAIL ADDRESS: keytorecovery7700@gmail.com

## ADVANCED STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

KTRTS appreciates the confidence you have shown in choosing us to provide your therapy needs. The service you have elected to receive implies a financial responsibility on your part. As a courtesy, we will attempt to verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

By signing below, you agree to the following terms and are:

1. authorizing KTRTS through its appropriate personnel, to perform upon named patient, appropriate assessment and treatment procedures; and stating your understanding that you have the right to ask and have any questions answered prior to receiving any treatment that has been prescribed for you;
2. stating your understanding that your insurance is a contract between yourself and that insurance carrier, and not between the insurance carrier and Key To Recovery Therapy Services / Cheryl D. Jones. I further understand that I am financially responsible for all charges of covered or non- covered services, services determined not medically necessary by your insurance carrier, any charges denied by your insurance carrier, or my election to continue therapy beyond approved insurance coverage. Should timely payments on this account not be made , I understand that KTRTS may retain the services of an attorney or collection agency to assist with the collection of any outstanding balance of my account. Any expenses incurred by such action shall become an additional liability for which I assume responsibility.
3. stating your understanding that deductibles, co-payments or co-insurance amounts as determined by your contract with your insurance carrier are due **AT TIME OF SERVICE.** We accept cash, VISA or check. Returned checks will be assessed an additional $25.00 per item, which **CANNOT** be billed to your insurance carrier and there will be an additional $3.50 service charge per credit card transaction;
4. **stating your understanding that there is a $25.00 cancellation /no show fee if cancellation is made with less that 24 hours notice. This fee must be paid prior to any further treatment rendered and CANNOT be billed to your insurance carrier; and**
5. stating that you waive your rights to the statue of limitations for any outstanding charges for services rendered until your account is resolved and paid in full.

| Guarantor/Patient Signature | Name Printed | Date | Relationship |
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## ASSIGNMENT OF INSURANCE BENEFITS/MEDICAL RELEASE AUTHORIZATION

I hereby authorize Key To Recovery Therapy Services / Cheryl D. Jones, to apply for benefits on my behalf for services rendered and request payment from my insurance company or claim to be made to named provider. I certify that the information I have provided with regard to my insurance coverage is correct and valid.

I further authorize the release of any necessary information, to my insurance company, consulting and/or referring physicians or attorney. This authorization may be revoked by myself at any time in writing to named provider.

| Guarantor/Patient Signature | Name Printed | Date |
|---|---|---|

## PHOTO RELEASE AUTHORIZATION

_____ **I DO** give permission for my picture taken for use in local newspaper articles/advertisements, Key To Recovery Therapy Services, Inc. newsletters, website and/or any printed literature.

_____ **I DO NOT** give permission for my picture taken for use in local newspaper articles/advertisements, Key To Recovery Therapy Services, Inc. newsletters, website and/or any printed literature.

| CLIENT/PARENT/LEGAL GUARDIAN'S SIGNATURE | DATE |
|---|---|

## HIPPA Notice of Privacy Practices

Your initials serve as acknowledgement that you have received the HIPPA Notice of Privacy Practices. _____