ASSIGNMENT OF BENEFITS
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I do hereby consent to such treatment by the authorized personnel of **Happy Hands Therapy Services** as may be dictated by prudent medical practice for my child's illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

I, the undersigned or designated representative for the patient, do hereby assign all medical benefits of which I am entitled **to Happy Hands Therapy Services** in the event they file insurance on my behalf. I understand that I am ultimately financially responsible for all charges whether or not paid by said insurance.

After obtaining all your insurance information prior to your child's initial visit, as a courtesy to our patients, **Happy Hands Therapy Services'** billing department will attempt to verify and explain your therapy benefits to you. **However, it is the patient's (parent/caregiver) ultimate responsibility to know what their therapy benefits are by calling their insurance provider themselves or by asking a member of our billing department to explain their therapy benefits. It is also the parent/caregiver's responsibility to disclose and show proof of all current health insurance coverages. If you fail to show all current insurances or if you discover continued unexpected coverage, we will not be able to bill or reimburse fees for treatment sessions prior to 90 days. If reimbursement is warranted, any discounts given at the time will be forfeited in the reimbursement since re-submitting claims causes increased costs to our clinic.**

All co-pays, coinsurance or deductible fees are due at time of services. **Happy Hands Therapy Services** will bill the insurance carrier as a courtesy to the undersigned patient. If the insurance carrier does not remit payment within the allocated 60 days, the balance due will be the responsibility of the patient. If the insurance company of record requests a refund of payment made, this will also be the responsibility of the patient. If any payment is made directly to the undersigned patient for services billed by **Happy Hands Therapy Services**, it becomes the patient's responsibility and obligation to immediately remit the same payment to **Happy Hands Therapy Services.**

This office reserves the right to charge for appointments **NOT** canceled 24 hours prior to schedule time. (Refer to the policy sheet initialed by the Parent/Caregiver)

I do hereby authorize **Happy Hands Therapy Services** to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
I do hereby authorize **Happy Hands Therapy Services** to release all information necessary to secure the payment of said benefits.

Thank you for allowing **Happy Hands Therapy Services** the opportunity to serve you. If you have questions regarding the above information or uncertainty regarding your insurance benefits, please ask for our assistance.

I have read and understand all above policies and I agree to them. I understand, per my insurance contract, I am financially responsible for any charges not paid by my insurance carrier.

_____ _____

Parent/Legal Guardian **Date**

2106 Rue Simone Hammond, LA 70403
Ph. 985-662-5448; Fax 985-222-2571; happyhandstherapy@yahoo.com