



Payment Agreement

Medicaid Patients:

ABG Therapy & Wellness Center, LLC are providers for Colorado Medicaid . We are glad to provide service to you, bill Medicaid and accept Medicaid Reimbursement, providing your eligibility is current and we have a Physician Order (Prescription) for therapy with diagnosis from your Primary Care Physician. The order has to be signed by a Physician - *not a Nurse Practitioner or Physician Assistant.* We need to be informed if there is any other insurance coverage involved along with Medicaid, even if insurance does not cover this therapy. These are Medicaid requirements. Please let us know whenever there is a change in physician, Medicaid status, address, telephone, insurance, etc.

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Insurance Patients: All patients require a prescription signed by their physician – *not a Nurse Practitioner or Physician Assistant*) before treatment can begin.

We are an “In-Network” provider for most major insurance companies. We will be responsible for billing our services to your insurance company. If we are “Out-of Network” and your insurance plan includes “Out of Network” benefits for therapy, we will also be happy to bill your insurance company. **Please note that you will be responsible for any deductible or coinsurance amounts as your plan dictates, and these will be collected at each visit.** Some plans require authorization to use your “Out of Network” benefits. Authorizations must be in place before therapy can begin. Authorizations are not a guarantee of payment.

Please note that each insurance company and insurance plan has its own Reasonable and Customary fee amounts. For plans in which we are “Out-of-Network, we will review the first explanation of benefits (EOB) from your insurance company, and at that time, make a determination as to whether we are able to accept what the insurance company deems as reasonable and customary. You may be responsible for the difference between my charge amount and the reimbursed amount. We will discuss this with you after the first EOB is received.

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Client Name: _____ Parent/Guardian/Name: _____

Signature of person responsible for payment: _____ Date: _____

Relationship to client: _____

Your signature indicates your agreement to the above terms and conditions. Preauthorization is NOT a guarantee of payment.