



**CREATIVE HANDS ABA**  
HELPING CHILDREN EXCEL

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## Financial Responsibility Agreement

(please initial next to each line)

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|  | I understand that I am ultimately responsible for payment to Creative Hands ABA for all services provided.  |
|  | I understand that Creative Hands ABA will verify my benefits for insurance carriers, however I understand a quote of benefits and/or authorization does not guarantee payment or eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at the time of service. If Creative Hands ABA cannot verify coverage for ABA therapy, invoices to the parent-guardian of the client will be due weekly until we establish coverage/pre-authorization with your insurance company.  |
|  | I understand that my health insurance will only pay for services that it determines to be 'reasonable and necessary.' Every effort will be made by Creative Hands ABA to have all services and procedures be pre-authorized by my health insurance company. If my insurance determines that a particular service is not reasonable and necessary or that a particular services is not covered under the plan, my insurer will deny payment for that service. I understand that I will be financially responsibility for any services deemed not covered by my designated funding source(s).   |
|  | I authorize Creative Hands ABA to submit claims for services rendered under my insurance plan on my behalf. I give Creative Hands ABA the authorization to bill my insurance directly and disclose/release any documents necessary or requested by the insurance company for service coverage or claim consideration. Additionally, I authorize and assign payment of medical benefits to Creative Hands ABA on behalf of the designated insurance benefit(s) at hand.  |
|  | I understand that my health insurance company may deny payment of services for any reasons including but not limited to the reasons stated above. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that I will be responsible for any copayment, deductible, or coinsurance that applies and is assessed to me for services rendered.   |
|  | I understand that if Creative Hands ABA is not in-network with my insurance company, <u>Creative Hands ABA will not file claims and payment of service is due upon receipt of my invoice.</u>   |
|  | I understand that in order for me to submit claims to my insurance company for out-of-network coverage, I will need a diagnosis code from a physician; Creative Hands ABA does not provide a diagnosis and insurance will deny a claim without a diagnosis code. If I wish to have the diagnosis code included on my weekly invoice, I must request the physician to fax Creative Hands ABA a copy of my child's diagnosis so this can be included on your weekly invoice. Additionally, sometimes other requirements are in place by specific funders such as pre-authorization of services. |

\_\_\_\_\_  
Parent/Guardian Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent /Guardian Signature

\_\_\_\_\_  
Child Name