



Patient Financial Liability Form

Thank you for choosing Building Bridges Through Communication (BBTC) for your home and community based therapy needs. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

- ❖ The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care.
- ❖ We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.
- ❖ Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Patients will receive an invoice by email once per week, for services rendered during the past seven days. The patient is liable for the amount billed and payment is due upon receipt of the invoice.
- ❖ We offer three payment options:
 - Zelle is a free service and our preferred method of payment
 - Payment may be submitted via email, megan@buildingbridgestherapy.org or by phone number 214-755-7504.
 - Auto draft
 - Account information will be provided upon request
 - Paypal
 - Payment may be submitted via email admin@buildingbridgestherapy.org
 - This form of payment requires an additional convenience fee of 3%
 - Credit card
 - You may keep a credit card on file and will have until the following Friday to review your invoice and contact our office with any questions or concerns. Unless we hear from you otherwise your card will be drafted on Monday, the 10th day, after your invoice was sent. This form of payment requires an additional convenience fee of 3%

- ❖ Patients may incur, and are responsible for the payment of additional charges at the discretion of BBTC. These charges may include (but are not limited to):
 - Charge for returned checks.
 - Charge for missed appointments without 24 hours advance notice
 - Charge for extensive phone consultations and/or after-hours phone calls requiring diagnosis, treatment, or prescriptions.
 - Charge for the copying and distribution of patient medical records.
 - Charge for extensive forms completion.
 - Any costs associated with collection of patient balances.
- ❖ By my signature below, I hereby authorize BBTC and the therapists and staff associated with BBTC to release medical and other information acquired in the course of my examination and/or treatment (with the exceptions stipulated below) to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.
- ❖ By my signature below, I hereby authorize assignment of financial benefits directly to BBTC and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- ❖ By my signature below, I authorize BBTC personnel to communication by mail, answering machine message, and/or email according to the information I have provided in my patient registration information.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

My preferred method of payment is:

_____ Zelle _____ Bank draft _____ PayPal _____ Credit Card

The email address to which invoices and receipt of payment are to be sent is:

Name of Patient

Name of Guardian

Signature of Patient or Guardian

Date Signed