IN-SYNC PEDIATRIC THERAPY CENTER

PERMISSION TO BILL

Insurance Billing

I,_____,give In-Sync Pediatric Therapy, LLC permission to **bill my insurance** for occupational, physical, and/or speech therapy services. I understand that insurance must be billed and Medicaid benefits can be utilized.

Personal Billing

I acknowledge that if there is a lapse of coverage due to losing Medicaid benefits, or private insurance coverage, In-Sync Pediatric Therapy, LLC will **bill me directly** for any dates of service that are not covered by my insurance.

The amount to be billed to the responsible party will be the current Medicaid rates for evaluation and/or therapy treatment.

_____ _____

Signature Date