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**La Luz Therapies, LLC.**

**Financial Policy**

Our financial policy is that each patient will pay for services at the time they are rendered unless other arrangements are made in advance of treatment. These optional arrangements are listed below. Please carefully read the policies as listed and check the one that applies to your case.

\_\_\_ 1. MEDICAID. You must provide evidence of current coverage, maintain coverage and notify us of any changes of coverage. Should your coverage end you are personally responsible for all charges not covered by Medicaid.

\_\_\_ 2. PRIVATE PAY: Services are charged directly to the patient. The patient is responsible for all fees. Signing below indicates acceptance of responsibility if this option is selected.

\_\_\_ 3. INSURANCE. We must have assignment of all benefits.

1. Coverage must be verified and authorization granted by your insurance company before treatment or you must pay for services at the time they are tendered. In addition, you must pay any co-pay amounts and services until all deductible amounts are satisfied.

If you have read this Financial Policy, selected the payment method most applicable to you and understand its contents, please sign below.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO LA LUZ THERAPIES, LLC. I ALSO REQUEST PAYMENT OF GOVERNMENTBENEFITS TO THE PARTY WHO ACCEPTS ASSIGNMENT. I understand that I am responsible for all charges incurred for therapy services.

**I understand that La Luz Therapies, LLC. DOES NOT provide testimony at dispositions, trials, or any other legal proceeding as that interferes with providing therapy services for others. You can ask your referring physician to refer you to another therapist, or agree to these conditions. If you choose to agree to these conditions, then please sign this form and instruct your attorney[s] to send us a Letter of Protection in regard to payment and to include a statement indicating their agreement with the conditions regarding testimony.**

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**