



THERAPEUTIC HORSEMANSHIP

332 Stable Lane
Wentzville, MO 63385
(636) 332-4940

Rider Name _____

Class Type: _____ Class Day: _____

Class Time: _____

Method of Payment
2010

Please read this form carefully. There are several important changes. At this time, Blue Cross Blue Shield Insurance will not pay for our services. We are working to try to change this. Therapy/Lesson fees must be paid for in advance, including those patients who ask us to bill their insurance. If you have First Steps, Medicaid or Regional Center funds, your services will continue as before. After you read through this form, please let us know of any questions about TH's payment policies by calling the office at 636-332-4940. We look forward to providing you/your child with a wonderful, therapeutic and fun riding experience.

Each Rider/Rider's Legal Guardian Must Complete This Form

NEW in 2010 - TH lesson fees will be charged monthly, in advance. Each payment is due on the 15th of the prior month and the entire month must be paid for. If we do not receive your payment, we will assume you are dropping your time slot.

TH accepts payment by **Cash, Check and Visa or MasterCard.**

Credit Card Information:

- MasterCard / Visa (circle one)
Name as it appears on card _____
Account Number _____
Exp. Date _____ 3 digit security code _____
Signature _____
- Please set me up on a monthly payment plan.

Alternate Forms of Payment

- I/We will seek payment for my/my child's lessons through one of the following agencies.

Please indicate which Third Party Provider you have made arrangements with:

_____ **REGIONAL CENTER** (serving the counties of Missouri through the Department of Mental Health) DMH # _____

- Family Directed Support
- Eastern Missouri Autism Project

We must have a copy of the Service Authorization and Input Document (P.A.I.D.) before you/your child can begin riding. You are responsible for contacting your case manager for pre-authorization. Services will not be paid for by Regional Center unless a P.A.I.D. form has been signed by the service provider (TH's Therapist); therefore, it is important to provide TH with your Case Manager's name and phone number. You will be responsible for any service units not pre-authorized so please be sure you know what has been approved.

Case Manager Name _____ Phone Number _____

_____ **FIRST STEPS – Department of Elementary and Secondary Education**

Case Manager Name _____ Phone Number _____

_____ **MEDICAID – You must provide TH with a copy of your Medicaid card with your registration materials.**

Medicaid # _____ **Therapeutic Horsemanship cannot accept payment from MC+ or Healthcare USA.**

_____ **BILL MY INSURANCE- No Blue Cross Blue Shield Insurance . You must provide TH with a copy of your insurance card with your registration materials.** TH requires you to pay the monthly therapy fee in advance, and then TH will submit the bill to your insurance. You should call your insurance provider to make sure services are covered. TH is considered an out of network provider. Services are billed as Occupational, Physical or Speech Therapy (CPT code 97110 or 97530). As before, you are responsible for any fees not covered by insurance.

Insurance Provider _____ Policy Number _____
Group Number _____ Primary Insured _____
Primary Insured Date of Birth _____

Statements of Financial Responsibility

I accept full financial responsibility for all therapy services provided to the client named in this application, regardless of third-party coverage. I assume full responsibility in the event that the third party provider denies payment in full or in part.

Rider/Legal Guardian Signature _____ Date _____

I authorize Therapeutic Horsemanship to provide any and all information to the above funding source in order for payment to be made on my/my child's behalf.

Rider/Legal Guardian Signature _____ Date _____