GUARANTEE OF PAYMENT

I agree to pay in full to KidsCare Therapy Center, Inc. for the services rendered to my child if:

1. The information provided of my insurance company is not accurate.
2. My insurance company changes, and I do not report these changes to the clinic in advance.
3. The pediatrician who ordered the therapy services for the patient does not want to sign the evaluation because the patient must be seen by the doctor in consultation first.
4. I do not communicate with the clinic within 15 days of submitting the evaluation to the medical office, and as a result the evaluation is not signed.
5. I decide to take the evaluations performed to another clinic, so my child can start to receive treatment somewhere else BEFORE receiving treatment at KidsCare Therapy Center.

In the event the account becomes delinquent, and is therefore in default of payment, a collection fee will be added to the unpaid balance. Please be aware that any remaining balances with KidsCare Therapy will be sent to a debt collection agency for payments.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you!

I hereby understand the above financial policy and agree to abide by it.

Credit Card Information

Credit Card#: ____

Expiration Date: _____/_____

CVV: __________

Billing Address: ____

____ ______/______/_________

Signature of Parent/Guardian of Child Date

6862 NW 169 Street
Hialeah. FL 33015
Phone: 786-615-8426
Fax: 786-801-1724
e-mail: kids_care.ML2017@hotmail.com

1140 W 50th Street Suite 303
Hialeah. FL 33012
Phone: 305-231-3371
Fax: 305-231-3382
e-mail: kids_care2013@hotmail.com