1800 Second Street NE, Minneapolis MN 55418 | 612-789-1236 | www.actg.org

INSURANCE AND SERVICE AUTHORIZATION FORM

Client Name: _____ Date of Birth: _____

A Chance to Grow Clinical services will bill my insurance company, for recommended medically necessary services. This includes Occupational Therapy and Speech Therapy, Auditory, and Vision services. If your insurance company denies these charges, for any reason that is outside of A Chance to Grow's billing responsibilities**,** you will be responsible for paying for the services.
If you are receiving Johansen Individualized Auditory Stimulation (JIAS), Neurodevelopmental Movement Integration (NDMI), or Neurofeedback, these services are strictly private pay and not covered by insurance.

You have the choice in how we bill your insurance for covered services, here are your options: Please choose one.

- ○ INSURANCE-BASED OPTION 1. I want to receive the recommended services at A Chance to Grow. Your insurance will be billed for an official decision regarding payment for each individual service and the dates they are provided. Please understand that if your insurance does not pay for any reason that cannot be corrected on our end, you are financially responsible for payment. You may appeal to the insurance company, if your insurance does pay, ACTG will refund any payment. (Minus copayments or deductibles)

- ○ PRIVATE PAY OPTION 2. I want the A Chance to Grow Services, but do not bill my insurance. ACTG may ask you to pay upfront, as you will then be responsible for payment. You cannot appeal if insurance is not billed. If your insurance is not a company that ACTG contracts with you may be able to submit to your insurance company for reimbursement. If you are receiving JIAS, NDMI, EEG, or AVE this is your only option.

A Chance to Grow will verify your insurance for active coverage, and determine benefits to the best of our ability with the information that your insurance company will share with us. We recommend that the policyholder also call to verify coverage, as they will have access to more information than a provider. If your insurance coverage has a copayment, please be aware that **Copayments are due at the time of service. You are required to make monthly payments on any balance that you accrue. We reserve the right to discharge from services for failing to meet financial obligations.**

Please complete the following insurance information for Option 1 only:

PRIMARY Insurance Company: _____

Name of Policy Holder: _____

Social Security Number of Policy Holder_____

DOB: (Policy Holder) _____ Policy Number: _____ Group Number: _____

Employer name & Address: _____

SECONDARY Insurance Company: (If applicable) _____

Name of Policy Holder: _____

Social Security Number of Policy Holder _____

DOB: (Policy Holder) _____ Policy Number: _____ Group Number: _____

Employer name & Address _____

By signing this form you understand that this gives A Chance to Grow, Inc. the right to verify and bill your insurance company. This form also acknowledges that you are aware that if for any reason services are not covered or they are denied for a reason that we cannot appeal you are financially responsible for the charges.

Signature _____ Date _____

(7/01/2018)