DISCOVERY
Behavior Solutions

COPAY ACKNOWLEDGMENT AND CONSENET

I acknowledge that as the parent/legal guardian of (child's full name) _____, and that I assume financial responsibility for any co-pay, deductible or co-insurance costs that are required by my health insurance plan under my benefits for ABA Services. I understand that it is my responsibility to know and understand my insurance plan benefits. I also understand that Discovery Behavior Solutions will process an invoice for any unpaid or denied portions of any claim that has been determined by my health insurance plan.

I agree to pay the invoiced amounts to Discovery Behavior Solutions within 30 days from the invoice date. Please write your child's name and date of birth below:

Child's Name_____ DOB: _____

IMPORTANT INFORMATION REGARDING LATE OR NON-PAYMENT:

Discovery Behavior Solutions has the right to suspend or terminate services in the event payments are late or unpaid. If you are having trouble making payments please contact us at (360) 984-3131. We would like to avoid suspending your child's services and will do what we can to work with you. Cancelled Check Fee: A $25 fee will be assessed for any checks returned by the bank.

_____

Legal Guardian First and Last Name Date

_____

Legal Guardian Signature Date