PATIENT PAYMENT POLICY
Innovative Hyperbaric Solutions of Newtown Square
3744 West Chester Pike, Newtown Square, Pa 19073

Innovative Hyperbaric Solutions of Newtown Square requires full payment for all services rendered. For your convenience we accept the following payment forms: cash, check, and most major credit cards. Checks should be payable to: Innovative Hyperbaric Solutions of Newtown Square. There will be a $25.00 fee for all returned checks.

We can help assist you in filing a claim with your insurance carrier. Please be aware that your insurance or other health care program coverage may not reimburse for therapies provided by Hyperbaric Therapy USA/Autism Treatment Center of Newtown Square, and it is your responsibility for determining your coverage if you wish to seek reimbursement. We offer special payment arrangements for those seeking compensation from an insurance provider, but please be aware that you are fully responsible for guaranteeing payment.

We understand the financial obligations that our patients face and offer a variety of payment options for your convenience. You may choose a payment arrangement below or speak to the office manager to make special arrangements for payment.

1. I, the undersigned authorize and request Hyperbaric Therapy USA/Autism Treatment Center of Newtown Square and/or associates, assistants to treat my condition with therapies offered.
2. I understand that I am financially responsible for all services rendered by Hyperbaric Therapy USA/Autism Treatment Center of Newtown Square. I understand that there are several payment options and plans available and I have been given the opportunity to choose how I plan to pay.
3. I have chosen the payment agreement below and agree to follow this plan. I understand that I have the opportunity to make amendments to this plan and agree to discuss any changes with the office manager.

PATIENT PAYMENT AGREEMENT:

_____ I plan to pay daily for each treatment received prior to the administration of therapy.

_____ I plan to pay weekly for all treatments received prior to the administration of therapy.

_____ I need to discuss other options for payment

Print Patient/Guardian Name: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____

HTLC Employee: _____ Date: _____

FOR OFFICE USE ONLY

Payment Arrangement_____
Employee initial _____

- ☐ **Physician Consultation – Biomedical, ASD**
- ☐ **Hyperbaric Oxygen Therapy**
- ☐ **QEEG**
- ☐ **Neurofeedback**
- ☐ **Behavioral Therapy Consultant**
- ☐ **IV Glutathione**