Speech Therapy Associates

Barbara Schwartz, M.A. CCC-SLP,
Leah Rubinstein, M.S. CCC-SLP
Jocelyn Arias- Flores M.Ed. CF-SLP

Patient Information **PLEASE PRINT CLEARLY**

Legal Name: ____ Chosen Name: _______________________

Date of Birth: ____ SSN: ________________________________

Address: ____ Apt/Space/Unit: ______________________

City:_________________________________ State: _________________ Zip Code: ______________________

Home #: _________________________ Cell: _________________________ Other: _____________________

Email: ____ Referred By: _________________________________

Emergency Contact: ______________________________ Phone: _____________________________________

Relationship to Patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other: _____________

Parent/Guardian/Spouse/Partner Information

Legal Name: ____ Chosen Name: _______________________

Date of Birth: ____ SSN: ________________________________

Home #: _________________________ Cell: _________________________ Other: _____________________

******* INSURANCE INFORMATION *******

Primary Ins Company: ______________________________________ Phone: ____________________________

Policyholder's Name: _______________________________________ DOB: _____________________________

Policyholder's SSN: ______________________ ID#: _____________________ Group#: __________________

Insurance Address: ____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other: _____________

Second Ins Company: _______________________________________ Phone: ____________________________

Policyholder's Name: _______________________________________ DOB: _____________________________

Policyholder's SSN: ______________________ ID#: _____________________ Group#: __________________

Insurance Address: ____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other: _____________

PLEASE READ THE FOLLOWING CAREFULLY:

All deductibles, co-payments, and applicable charges will be due at the time of service **NO EXCEPTIONS**. I hereby authorize the release of information necessary to file a claim with my insurance company. The above information is complete and correct. I assign benefits otherwise payable to me, to Speech Therapy Associates. All professional services rendered are charged to the patient. **The patient is responsible for all fees regardless of insurance coverage.** In the event of collection proceedings due to lack of payment on my part, I agree to pay all collection fees that may be added to my account to recover money due.

Patient/Guardian Signature: ____ Date: ______________________________

SPEECH THERAPY ASSOCIATES

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IMPORTANT INFORMATION ABOUT YOUR VISITS AND THERAPY SESSIONS

PLEASE NOTE: IF YOU ARRIVE **10** MINUTES OR LATER FOR YOUR SCHEDULED APPOINTMENT **YOU WILL NOT BE SEEN**. THE APPOINTMENT WILL BE CANCELED AND RESCHEDULED. TWO OR MORE LATE ARRIVALS WILL RESULT IN DISCHARGE AND THE REFERRING PHYSICIAN WILL BE NOTIFIED.

YOUR INSURANCE IS ULTIMATELY YOUR RESPONSIBILITY

PLEASE REVIEW THE FOLLOWING:

- DOUBLE CHECK WITH YOUR INSURANCE COMPANY TO DETERMINE IF **AUTHORIZATION** IS REQUIRED FOR YOUR VISITS.
- **PLEASE NOTE AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. BENEFITS ARE REVIEWED AT THE TIME THE CLAIM IS SUBMITTED.**
- IF YOUR VISIT IS DENIED FOR **ANY REASON**, YOU WILL BE BILLED FOR THE SERVICES.
- WE ARE **NOT** RESPONSIBLE FOR CHECKING YOUR BENEFITS, THIS IS A COURTESY AND WE CAN NOT GUARANTEE ANY INFORMATION WE RECEIVE FROM THE INSURANCE COMPANY.

- ALTHOUGH THERE IS A 24-HOUR CANCELLATION POLICY WE REALIZE AN EMERGENCY CAN OCCUR AND ASK THAT YOU CALL US AS SOON AS YOU CAN TO NOTIFY US OF ANY NEED TO CANCEL YOUR APPOINTMENT.
- IN ADDITION, IT IS OUR POLICY IF YOU OR YOUR CHILD ARE SICK THAT YOU CANCEL YOUR APPOINTMENT AS TO NOT SPREAD GERMS TO OTHER PATIENTS AND STAFF.
- FOR YOUR CONVENIENCE WE DO HAVE A 24-hour ANSWERING MACHINE AVAILABLE TO ACCEPT CALLS WHEN OUR OFFICE IS CLOSED. PLEASE LEAVE A DETAILED MESSAGE INCLUDING THE PATIENT'S NAME, APPOINTMENT DATE, AND CALL-BACK INFORMATION.

Please review our posted Privacy Policy Notice. This Notice of Privacy Practices provides detailed information about how we may use and disclose your medical information with or without authorization as well as more information about your specific rights concerning your medical information.

********Please feel free to clarify any questions with our staff. ********

I HAVE READ, UNDERSTOOD, AND AGREE TO THE ABOVE INSURANCE/OFFICE POLICIES. THE PATIENT IS ULTIMATELY RESPONSIBLE FOR THEIR INSURANCE REQUIREMENTS.

____
PATIENT/GUARDIAN/POA PRINTED NAME

____________________________________ ____________________
SIGNATURE DATE

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NO-SHOW, LATE CANCELLATION, AND COLLECTION CHARGES

All no-show appointments canceled less than 24 hours in advance are subject to the patient being charged in full for that missed appointment. It is further understood that this fee is not a Medicare, Medicaid, or commercial insurance benefit and that it is the patient/guarantor's responsibility to pay the no-show charge and/or late cancellation charge.

NO-SHOWS:
The charge for the no-show appointments will be as follows:
Each missed appointment = $80 charged
After the second no-show, the patient will be discharged, and the referring physician will be notified.

LATE CANCELLATION FEE:
Less than 24-hour cancellations are subject to the $80 fee. **We have a 24-hour answering machine available to accept calls when our office is closed.** After 2 or more late cancellations the patient will be discharged, and the referring physician will be notified.

COLLECTION FEE:
In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay **all** collection/legal fees that may be added to my account.

I have read, understood, and received a copy of this policy.

____
PATIENT/GUARDIAN/POA PRINTED NAME

____ ________________________
SIGNATURE DATE

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RELEASE OF INFORMATION

I HEREBY AUTHORIZE CORRESPONDENCE, EITHER BY
PHONE, FAX, EMAIL, OR MAIL REGARDING:

____
(PATIENT NAME & DOB)

BETWEEN SPEECH THERAPY ASSOCIATES AND THE FOLLOWING OFFICE(S) and/or PERSON(S):

Name: ______________________ Relation: ______________________

Name: ______________________ Relation: ______________________

Name: ______________________ Relation: ______________________

Name: ______________________ Relation: ______________________

Name: ______________________ Relation: ______________________

Please disclose the following information from my medical chart:

( ) Eval/Consult Report **( ) Progress Notes**

( ) Complete Medical Records **( ) Other: ______________________**

Please note: ______________________ has Durable Power of Attorney for my

☐ Medical and/or ☐ Financial care (please select one or both if applicable)

Patient/Guardian Signature: ______________________ Date: ______________

POA (if Applicable) Signature: ______________________ Date: ______________

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** For AETNA and BCBS-insured patients **

Please be aware that your insurance may deem your diagnosis to be experimental or medically unnecessary. We will do our best to get the claims appealed if they are denied, but if these attempts fail, you will be responsible for the payment of the services provided.

******** Please feel free to clarify any questions with our staff. ********

☐ I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE INSURANCE/OFFICE POLICIES. I ACKNOWLEDGE THE PATIENT IS ULTIMATELY RESPONSIBLE FOR THEIR INSURANCE BENEFITS AND REQUIREMENTS.

☐ I HAVE READ, UNDERSTAND, AND ACKNOWLEDGE THAT I DO NOT HAVE EITHER AETNA OR BCBS INSURANCE AND THIS STIPULATION SHOULD NOT APPLY TO MY SERVICES.

____
PATIENT/GUARDIAN/POA PRINTED NAME

____ _______________________
SIGNATURE DATE