

Financial Policy and Consent for Services



Therapy Talk
Pediatric Speech, Occupational and Physical Therapy

This patient or legal guardian gives consent for procedures and treatment as ordered by physician. I understand and agree that Therapy Talk, Inc will not be liable in the event that scheduled services cannot be provided as requested, or when insufficient notice is given concerning canceled services.

With this consent, Therapy Talk, Inc. may call, email or text clients in reference to any items that assist in the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to clinical care. It is our philosophy that communication is a vital part of effective therapy. **Our Office hours are from 8am - 5pm. Please do not text therapists directly outside of these hours unless you have a cancellation.** My preferred form of communication is:

Email _____ Text: _____ Phone call: _____

Please read the statements below and Initial in the boxes:

☐Patient Acknowledgement of Notice of Privacy Practices I acknowledge by signing below that I was made aware of the Notice of Privacy Practices that are posted on www.TherapyTalk.org. If I would like a copy of these Privacy Practices, I will request them by contacting Office@TherapyTalk.org or by calling 704-239-6321.

☐Authorization to Release This patient or legal guardian consents to the release of information by a school, hospital, physician, developmental evaluation center, health department, or other agency where a child was evaluated to Therapy Talk, Inc. I also authorize Therapy Talk, Inc. to disclose all or part of my medical information to any agency to benefit my care such as coordinators, daycare staff, teachers, family members, members of IEP, IFSP team, physicians, nutritionists, orthotist, and _____. This release is valid for seven years from the date signed below. You may revoke your authorization in writing at any time.

☐Private Insurance/Medicaid This patient or legal guardian agrees to authorize direct payment of insurance benefits by insurance carrier to Therapy Talk, Inc. I understand that if my insurance carrier does not accept "assignment of benefits," I am obligated to endorse and send payments to Therapy Talk, Inc. I understand that Therapy Talk, Inc. is enrolled as a provider with Medcost, BCBS, and North Carolina Medicaid. This patient or legal guardian agrees to notify Therapy Talk, Inc. within 24 hours of any information change it receives regarding changes in Insurance, Medicaid, or other funds that affect the reimbursement.

☐Client Financial Responsibility With this consent, Therapy Talk, Inc. may verify insurance coverage for Occupational, Physical, and Speech Therapy services. I understand that verification of benefits is not a guarantee of payment and I understand that if payment is not made to Therapy Talk, Inc. by other payers or by client's family, I will be responsible for the services rendered to my child. This payment will be made dependent upon a written or emailed notice. I understand that I am responsible for insurance deductibles and amounts not covered by any insurance or payment provider. Co-pays, deductibles and coinsurance are due at the time of service. In the event that you carry an account balance 60 days from your initial statement, you will be assessed a late fee of 15% of the balance (minimum of \$20) monthly until paid in full. If the balance is not paid upon the 120th day, your account will be sent to a third party collection agency. If your insurance delays payment and the balance is past 60 days, the balance is your responsibility and is due immediately.

☐Attendance and Cancellation Policy Repeated cancellations may result in either forfeiture of permanent appointment or termination of service. **Failure to contact the office/therapist 12 hours prior to appointment time may result in a \$25.00 No Show fee.** Cancellation fees are not reimbursed by insurance companies or Medicaid and will be billed to the responsible party. Due to the nature of home health therapy, a 15 minute window should be allowed for the therapist to arrive. We will contact you if we are going to be later than 15 minutes for an appointment. If a parent or guardian cancels 50% of the sessions for two consecutive months or has 3 no shows, Therapy Talk, Inc. reserves the right to discontinue services with the family.

☐Therapy Sessions OT, PT, ST services vary in time length. Each session will not be exactly one hour, 30 minutes or the same length every session. It truly depends on the child and how the individual session is progressing. Therapists work with children AND caregivers to educate and also to provide direct treatment. Parental or Caregiver coaching is a huge part of therapy and is also part of the therapy session as a whole.

Client's Name Birth Date

Signature of Parent/Legal Guardian/ DATE