PATHWAYS
SPEECH THERAPY INC.

Payment Policy

We are committed to providing you with the highest quality care. Please know that the timely payment of your bill is an integral part of our service and as such, this payment policy is an agreement between you and Pathways Speech Therapy, Inc. for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family member.

Please read the following information carefully:

All therapy fees (including deductible, co-pays or co-insurance) are due at the time of service.

Patient Insurance: _____
Medicare Therapy Dollars Used (If applicable): _____
Deductible: _____ Met: _____
Co-Pay: _____ Co-Insurance: _____
OOP Met: _____ Visit Limit: _____

Please read and check of all boxes to acknowledge understanding and the sign below:

☐ **I understand** that I am responsible for all costs / fees that any third-party payer (ex. insurance company, private school, etc.) does not cover. In the event that a third-party payer source determines that rendered therapy services are "not covered" or otherwise denied, I will be responsible for all outstanding charges. I understand that I will be billed accordingly and will be responsible for immediate payment. I also understand that Pathways Speech Therapy Inc. will not become involved in disputes between you and your third-party source regarding uncovered charges or reasons for denial.

☐ **I understand** that all returned checks will be subject to a $25 returned check fee. Charges incurred and not paid after 30 days may be turned over to a collection agency at the patient's expense. Overdue accounts may also be reported to a Credit Bureau.

☐ **I understand** that I am responsible for all legal and collection fees, which Pathways Speech Therapy Inc. may incur if payment is not made in accordance with the terms and conditions herein.

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☐ **I understand** that refunds will be issued only in instances of overpayment. All refunds will be processed within 8 weeks after the overpayment is discovered on the patient's bill or at the time the refund is requested. Refunds for payments made with a credit card will be credited back to the credit card used, all other refunds will be issued by a check. Patient's who used a third-party source will not be issued a refund until full payment is received from the appropriate source.

☐ **I understand** that all cancellations require 24 hours notice and that there will be a charge of $25 for any cancellations made less than 24 hours. This charge is my sole responsibility and will not be covered by a third-party source.

☐ **I understand** that a no call/ no show will result in a $25 no show fee that is due prior the next scheduled appointment. This charge is my sole responsibility and will not be covered by a third-party source.

☐ **I understand** that after 3 no call/no show appointments or any unpaid fees, the patient will be discharged from the care of Pathways Speech Therapy, Inc.

☐ **I understand** the payment policy and the risks of not adhering to it.

_____	_____
Print Name of Patient	Date
_____	_____
Signature of Patient or Responsible Party	Relationship to Patient
_____	_____
Private Practitioner / Witness	Date