Financial Agreement and Insurance Policy

The Speech and Language Center and Speech Therapy Solutions, Inc. will file insurance claims for payment of services rendered. If no payment has been received within 65 days from the insurance company, you agree to pay balance in full. If family receives a bill that is not paid within 30 days of receipt of invoice, there will be a 10% monthly late fee added and services risk being put on hold.

_____Patient/Parent Initials

Insurance information will be needed before services begin to verify benefits. A copy of your insurance card(s) will be requested. Benefits will be verified upon receipt of your insurance information and you will be made aware of any estimated out-of-pocket expenses before services are started. **Information gained from insurance companies during verification of benefits, however, is not always guaranteed.** It is imperative that families are aware of their insurance coverage and their potential responsibilities. We will strive to keep open communication in regard to insurance and payment. We encourage you call your insurance company to verify benefits, be sure to ask for exclusions.

_____Patient/Parent Initials

I agree to be responsible for deductibles, coinsurance, copays, and any non-covered portions of services provided. Copays are due at the time of service. As in all healthcare situations, the client-family is always responsible for payment when all other sources have been exhausted. Therapy services may be put on hold or terminated if there is a problem regarding payment.

_____Patient/Parent Initials

We can no longer hold large patient balances. If the balances reaches or exceeds $500, therapy services will be put on hold until a payment plan can be established.

_____Patient/Parent Initials

Deductible pre-payment policy

Effective August 27, 2018, all patients with deductibles will be responsible to pay the fee schedule rate for each date of service. This must be paid at the time of service. If the deductible has been met, you will be reimbursed the difference and/or your account will be credited.

_____Patient/Parent Initials

Change of Insurance

I agree to notify *The Speech and Language Center and Speech Therapy Solutions, Inc.* immediately if there are any changes to insurance. Change of insurance does not guarantee coverage of therapy services. If there

is failure to notify *The Speech and Language Center and Speech Therapy Solutions, Inc.*, you will be responsible for paying the self-pay rate for interim visits.

_____Patient/Parent Initials

Returned Checks

There will be a $25 charge for all returned checks.

_____Patient/Parent Initials

Discharge of Therapy

When discharge from services is planned, you will be required to pay your account balance in full on the last date of service.

_____Patient/Parent Initials

Cancellation Policy

The Speech and Language Center and Speech Therapy Solutions, Inc. appreciates cancellation requests as early as possible to allow for us to accommodate other families and/or therapist needs. However, we **require** 24-hour cancellation for any reason. Any cancellation after 7:00 a.m. on the scheduled date of service, except for emergency (illness, death in the family, birth of a sibling, family emergency) will be subject to **late cancellation fee of $60**. This fee will be waived if your visit is rescheduled within the same 2-week period. Cancellation notification must be done through phone call, email to your therapist, or email to the office director jillian.hertel@speech-languagecenter.com.

All appointments missed without notification (no show) will be subject to a $60 fee. The no show fee is not covered by insurance or other third-party payer and must be paid in full no later than your next appointment. The no show fee may be waived if the visit is rescheduled within the same 2-week period. **3 no shows will result in immediate discontinuation of services.**

_____Patient/Parent Initials

Snow / Inclement Weather Policy

The Speech and Language Center and Speech Therapy Solutions, Inc. closes in extreme weather when roads are impassible, a state of emergency has been issued by the governor of MA, or loss of power to our building. Our voicemail and FaceBook page will be updated upon decision to close. You will also be notified via email and/or phone. We will make every attempt to reschedule your visit within the same week or 2-week period. We do not follow school closures, delays or early releases due to weather.

_____Patient/Parent Initials

Holiday Closures

Please note, we are closed New Year's Day, Memorial Day, July 4th, Labor Day, Thanksgiving Day, and Christmas Day. We are open regular business hours all other days of the year. We do not follow school holidays or early release schedules.

Attendance

In order to make optimal progress, it is important to attend all scheduled therapy sessions. Excessive missed appointments, cancellations or 3 no shows will result in immediate discontinuation of services.

Please speak with your therapist if the time/day schedule no longer works for you, if you require a break in services. If you do require a break, the day/time may not be available upon return. The therapist will make every attempt to accommodate your scheduling needs.

It is important you are on time to your therapy visit. If you will be late to the appointment, please call the office to inform your therapist. The therapist will end the session at the scheduled end-time. The therapist will use their discretion whether they can extend the session beyond the scheduled end-time.

Visits billed to insurance cannot be charged **any less than 20 minutes**. Visits 20 minutes or less are subject to the $75 private pay rate and will be expected at the time of visit.

_____Patient/Parent Initials

All of our therapists work with medically fragile children and we don't want to carry sickness to other families, infect ourselves or our own families. Please be respectful and cancel therapy appointment(s) if your child is sick.

The Board of Health considers the following signs to indicate communicable disease/illness: vomiting, fever >100, diarrhea, sore throat, rash/swallowing red/running eyes. Please be sure your child is symptom free for 24 hours prior to resuming therapy. Sick calls for these reasons are not subject to fee for missed visit.

_____Patient/Parent Initials

This form has been fully explained to me and I certify that its contents and accept its terms.

Parent/Guardian Signature: _____

Relationship to the patient: _____

Date: _____