Rescue My Speech
Pediatric Therapies

Payment Agreement

By signing this document you are entering into a binding agreement between Rescue My Speech and the Patient who is receiving therapy services, or the Responsible Party for minor patients (under 18 years of age). The Responsible Party is the individual who is financially responsible for payment of medical bills.

ALL CHARGES FOR SERVICES RENDERED ARE DUE AT TIME OF SERVICE.

For Patients with Medical Insurance. We have contracts with many insurance companies, and we bill them as courtesy to you. As the Responsible Party, you are responsible if your insurance company denies payment for any reason.

The Responsible Party must:

*Inform Rescue My Speech of any address, phone number, or insurance changes.
*Pay the required copayment amount at the time of visit.

For Date of Service Patients: Rescue My Speech is offering a discounted rate to patients who pay ON the DATE OF SERVICE. If payment is not received on the date service is rendered the charge will be increased to reflect the current therapy rate of $150.00 per session. This rate is subject to change without notice.

Return Check Policy
If a payment is made with a check, and the check is returned for any reason the patient will be responsible for the original amount plus a $35.00 service fee. If a response is not made 15 days from the date the notification letters mailed then the account will be turned over to collections. Additionally the collection fees will be added to the outstanding account.

Non-payment of an account
Should a collections agency or legal action become necessary to settle your account The Responsible Party understands that Rescue My Speech has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect for services rendered. The Responsible Party understands that they are responsible for all costs of collection, but not limited to, interest due at 20% APR, all court costs, attorney fees, and collection fee added to outstanding balance.

By signing bellow, you agree that you have read, understand, and agree to full financial responsibility as the Responsible Party.

_____ _____

Patient Name Responsible Party Name/Relationship

_____ Date:_____

Responsible Party Signature

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CANCELLATION POLICY

WARNING: You will be charged a $30.00 FEE for all appointments that are not cancelled 24 hours prior to your scheduled visit. This allows us to make your appoint time available to another patient. After 2 instances of a “no call / no show” you will lose your appointment time.

Patients who fail to provide 24 hour notice before canceling their appointment on 3 occasions will no longer be able to receive services at Rescue My Speech.

We will send outstanding balances that are not paid in a timely manner to a collection agency.

Your child’s time with me is important. In order for your child to receive the full benefit or services it is important that you arrive to your appointment in a timely manner. Appointments will not run over for patients who arrive late. ***If you are late and arrive more than 15 minutes late your appointment will be considered a “no call / no show” and you will be charged.***

Thank you for your cooperation.

I have been informed of the cancellation policy:

_____

Printed Name

_____ _____

Signature Date

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Authorization Form Policy

Protected health information(PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, except for treatment , payment, or health care operations (TPO) and as otherwise required by law. Examples or some instances in which we are required to disclose your PHI include:

Public health activities; information regarding victims of abuse, neglect, or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; organ donations purposes; research purposes under certain circumstances; national security and intelligence; correctional institutions; and Worker's Compensation.

RESCUE MY SPEECH will only use or disclose PHI, except as noted above, consistent with the terms of the authorization.

A patient may revoke his authorization to use or disclose PHI at any time but actions taken prior to the revocation are excluded. If authorization is a condition of obtaining insurance coverage, and the authorization is revoked, the insurer may contest a claim under the policy.

Authorizations must be properly executed by the patient or his/her personal representative. It should include, the date signed, specific PHI to be released or used, to whom this use or release relates, and an expiration date for the authorization.

_____ _____

Patent or Representative Signature Date