# INSURANCE INFORMATION &
# FINANCIAL STATEMENT AND POLICY

CLIENT:_____ DATE OF BIRTH: _____

PRIMARY INSURANCE COMPANY: _____
NAME ON CARD:_____ PARENT DATE OF BIRTH:_____
ID NUMBER:_____ GROUP NUMBER:_____

SECONDARY INSURANCE COMPANY: _____
NAME ON CARD:_____ PARENT DATE OF BIRTH:_____
ID NUMBER:_____ GROUP NUMBER:_____

## AGREEMENT/AUTHORIZATION FOR SERVICES

(1) I give permission for my child to receive a speech and language evaluation. I understand that enrollment in a treatment program may be recommended. I understand that, at times, scheduling may be limited. If need be, I understand that I will be contacted when a space becomes available. If Aspire Speech Therapy is unable to accommodate me, other professionals/agencies may be recommended. The primary clinician may change based on schedule needs across the clinic, and attendance is expected. (2) **Payment is expected at the time of service,** unless prior arrangements have been made. Clients who carry medical insurance accepted by Aspire Speech Therapy should remember that all professional services are rendered and charged to the client, not the insurance company. It is my responsibility to know what coverage is provided by my insurance company. **In the event that the insurance company does not pay within forty-five (45) days, I will be expected to pay the total balance of this account, and I understand that if my account is turned over to a collection agency I will be responsible for all charges encountered in the collections process.** (3) It is my responsibility to notify Aspire Speech Therapy **prior** to any insurance changes even if I have Medicaid coverage as adding or changing a primary insurance may require prior authorization for services. We require 72 hours notice to request authorization. If prior authorization is not obtained secondary to not notifying Aspire Speech Therapy about the change in insurance, I will be responsible for services not covered by insurance (applies to clients covered by Medicaid). (4) It is my responsibility to notify Aspire Speech Therapy regarding prior therapy services received as well as future decisions to seek therapy services from other service providers. I understand that seeing multiple providers may affect my insurance coverage, and I will be held responsible for any balance due should billing complications arise (applies to clients covered by Medicaid). In the event that Aspire Speech Therapy has to back bill for payment from an insurance agency I will be charged a $25.00/hr administration fee. (5) I understand that

Aspire Speech Therapy will honor new Medicaid coverage moving forward from the time a family provides a copy of the insurance card and after prior authorization has been approved by Medicaid. Please note that the administrative staff is unable to bill Medicaid retroactively, even if Medicaid authorizes retroactive billing. (6) If I am responsible for a full/partial payment or a co-payment amount, **I authorize my credit card to be charged the full amount due.** Aspire Speech Therapy will make every effort to give advance warning that the charge will be made. (7) I authorize the release of any medical or other information necessary to my insurance company to process claims.

Name on Credit Card:_____
Type of Credit Card (e.g., Master, Visa):_____
Credit Card Number:_____
CVC_____
Expiration Date:_____ Zip Code: _____
Number of therapy sessions attended at other place of service: _____

Signature of Parent/Guardian_____ Date_____

3983 S. McCarran Blvd. #244, Reno, Nevada, 89502, Phone: (775) 451-7220 Fax: (775) 451-7221