



PAYMENT POLICY

Thank you for choosing us as your speech provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance. We participate in most major insurance plans. ***If you are not insured by a plan we do business with, payment in full is expected at each visit.*** If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. A questionnaire is sent prior to your first visit in order to obtain information about your insurance policy. Our Billing Specialist will conduct a pre-authorization to reconfirm your policy.

Co-payments and Deductibles. ***All co-payments and deductibles must be paid at the time of service.*** This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Non-covered Services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable. You must pay for these services in full at the time of visit.

Proof of Insurance. All patients must complete our patient information form before receiving speech therapy. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims Submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.



_____ **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

_____ **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice.

_____ **Missed appointments.** *Our policy is to charge a fee of \$30 for missed appointments not canceled within a reasonable amount of time of 24 hours.* These charges will be your responsibility and billed directly to you. *Should you miss three (3) appointments, or, if you do not appear for three (3) scheduled appointments, we will no longer be able to provide our services to you or your child.* We understand emergency situations occur, thus you will not be charged for your absenteeism. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of client or responsible party

Date

Print Name