Clinic Policies and General Information

Patient Name: ____ DOB: ____________________

Parent or Guardian (if minor): _________________________________

Insurance Policy:

Speech and Language Connections is a provider of service that accepts insurance. Insurance information is required in advance of the first appointment to submit claims to the insurance company. Deductible, coinsurance and fees for non-covered services will be the responsibility of the client/caregiver of the client receiving services. This includes any charges not paid by the insurance company for any reason, regardless of the Explanation of Benefits (EOB).

It is the responsibility of the patient or patient representative to contact their insurance company to find out whether or not Speech and Language Connections is an in network participating provider with their plan and to determine speech therapy benefits.

It is the patient's responsibility to notify Speech and Language Connections immediately of any insurance changes. It is also the responsibility of the patient or patient representative to contact their new insurance company to find out whether or not Speech and Language Connections is an in network participating provider with their new plan and to determine speech therapy benefits.

In the event the patient does not inform speech and language connections of such changes prior to the time of services, the patient will be responsible for the charges for the services provided.

Referrals & Authorizations:

It is the patient's responsibility to get a referral from their Doctor or insurance company, if the insurance carrier requires a referral. In this case, a referral must be obtained prior to the scheduled appointment. If no referral exists on file or the referral has not been received, the appointment will be cancelled.

Speech and Language Connections will obtain prior authorization for the evaluation and/or treatment prior to scheduling the appointment when applicable. Speech and Language Connections suggests that the patient contact their insurance carrier to verify coverage, benefits, referral and pre-authorization requirements prior to receiving any speech therapy services. Claims are paid based on medical necessity and coverage parameters documented in patient's insurance plan. Please be aware authorizations and referrals are not a guarantee of payment.

Financial Obligations:

Some insurance plans may not cover services performed by Speech and Language Connections. It is the patient's responsibility to verify coverage and benefits with their insurance company. Patient is responsible for all charges for services provided regardless of any insurance coverage.

Payment Policy:

All fee for service payments, co-payments, co-insurance, and/or deductible amounts are due at the time of service. Speech and Language Connections accepts cash, checks, Visa, MasterCard, Discover, and American Express.

Monthly statements will be sent to patient if there is an outstanding balance on their account. Payment of statement charges are due upon receipt.

A $50.00 fee will be applied for all returned checks due to closed account, stop payment or non-sufficient funds.

Delinquent accounts may be reported to a collection agency following normal collection procedures. Agency, legal, other associated collections fees incurred, and interest will be added to any outstanding balances.

Attendance

Good patient attendance is necessary to achieve maximum benefit from therapy. Therefore, Speech and Language Connections will attempt to re-schedule patient cancellations due to illness.

We request that non-emergency cancellation notices be given as soon as possible, but no later than 24-hour in advance. No Shows and late cancellations will incur a $50.00 fee, which will be charged to the patient directly.

If attendance falls below 80%, Speech and Language Connections will meet with you to find a more suitable appointment time, as it is necessary to follow your treatment plan. Continuity of care will ensure the best treatment results.

____ Date__________________

(Patient/Guarantor Printed Name)

____ Date__________________

(Patient/Guarantor Signature)