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## FINANCIAL RESPONSIBILITY

Payment is required at time of service. If for any reason we are unable to verify insurance eligibility prior to office visit, you are responsible for full payment upon services being rendered. You are responsible for the full balance due, if your insurance does not provide coverage for speech therapy or fails to pay the amount in full.

**Verification of benefits is not a guarantee of payment.** You are responsible for any charges not covered by your insurance. Benefits are subject to eligibility at the time of service. All specific plan provisions, exclusions and limitations will be applied at the time the claim is processed.

I understand I am responsible and will pay for all the following charges before my child attends the next therapy session:

CO-PAYMENTS – due at time of service

PRIVATE PAYMENTS – due at time of service

LATE CANCELLATION - \$40 (24 hour notice is required unless sudden illness or other understandable excuse is provided in a timely manner)

RETURNED CHECKS - \$35.00/check

NO SHOW CHARGES – \$40

Please indicate your preference and sign below. (*Check one only*)

I agree to directly pay Speech and Motion Therapy for all services.

Speech and Motion Therapy should bill my insurance carrier.

Speech and Motion Therapy will provide me the information to bill my insurance carrier.

**I, the undersigned, understand the above conditions to be a legally binding agreement.**

Signature \_\_\_\_\_ Date \_\_\_\_\_