Anderson-Smith
SPEECH THERAPY LLC

Financial Contract Regarding Services Rendered to _____
(PRINT Full Name of Patient)

Payment

A. You accept financial responsibility for all charges not paid by the insurance carrier(s) and agree that a photocopy of this agreement will be considered the same as the original.

B. Payment is due for all services that are the responsibility of the client at the time services are rendered or when invoiced by Anderson-Smith Speech, Feeding and Myofunctional Therapy, LLC.

C. Returned checks will incur a $30 service fee.

D. You may request an invoice at the time services are rendered.

E. In a matter of divorced parents, payment is still due at the time of treatment or invoice, regardless of the terms outlined in a divorce decree. Any balances will be the responsibility of the parent who signed this financial contract, which would include missed visit charges.

Fees

A. Rates are based on the individual client's diagnosis and procedure.

B. We accept negotiated rates from insurance carriers for who we are providers.

C. Any financial responsibility information provided by Anderson-Smith Speech, Feeding and Myofunctional Therapy, LLC is not guaranteed and just an estimate, regardless of information provided to you, the client, or the clinic by your insurance carrier prior to services being rendered.

D. Claims will be resubmitted twice as a courtesy. If payment is not received at this point the fee for services rendered will be billed to the client.

In Network Insurance Clients with Benefits

Your policy is a contract between you and your insurance company. We are not a party to that contract. As a network provider, we agree to provide treatment at a negotiated rate and within the constraints of our contract with the insurance company. We will provide necessary information to the insurance carrier to obtain pre-authorization for therapy under managed care policies. We check benefits for you, but this is not a guarantee of coverage. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered medically necessary under your individual policy. In this case, you agree to be fully responsible for these charges. Balances remaining on your account after 60 days, due to difficulty with claims resolution will be your immediate responsibility. For self-funded policies, in the event that your Plan Sponsor (employer) becomes insolvent or otherwise fails to pay us, (for covered services per verification), you agree to pay the outstanding balance on your bill.

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In Network Insurance Clients Who Do Not Have Benefits Under Their Policy

We have checked your benefits and you have been informed by your insurance company that some or all of the services you need are not covered under your policy. This is either due to policy exclusions or not meeting your policy's definition of Medical Necessity. This is your acknowledgment that you will be financially responsible for these non-covered services as outlined in this agreement.

Clients with Out-of-Network Benefits

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is your responsibility to collect reimbursement from your insurance company. We will send the insurance company any requested additional records that are required to process your claims

Clients Without Insurance or Who Are Not Using Insurance

If the therapy expenses are not covered by your insurance policy or you are private pay, keep the invoices to submit with income taxes as a medical deduction.

I have read, understand, and agree to the above financial policy for payment of professional fees. By signing this agreement I am assuring Anderson-Smith Speech, Feeding, and Myofunctional Therapy, LLC that I have permission to use policy holder's insurance to cover services, if applicable.

_____ _____ _____

Signature of Patient or Responsible Party Relation Date