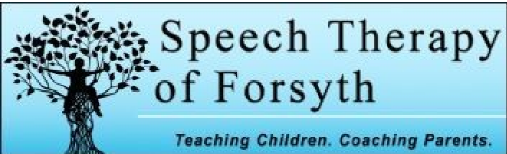

Pediatric Speech Therapy of Forsyth, LLC
4080 McGinnis Ferry Rd.
Bldg. 300, Suite 302
Alpharetta, GA 30005
770-410-7719 (Fax) 770-410-9510

Agreement of Services and Payment Policy

To ensure a smooth course of Speech/Language and/or Occupational Therapy treatment for your child, please review our payment policy and ask us any questions you may have. After reviewing, please sign in the space provided indicating your understanding of this Agreement.

1. **Insurance.** We participate in several insurance plans, including Medicaid, Wellcare, Amerigroup and PeachState. We are currently in-network with Aetna, Blue Cross and Benefit Support, Inc. 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 payment in full for each visit may be required up front until we can verify insurance coverage. We will file insurance claims to your primary and/or secondary carriers for your convenience. However, <u>knowing your insurance benefits and limitations is your responsibility</u>. Please contact your insurance company with any questions you may have regarding your coverage for Speech and Occupational Therapy, the diagnoses covered, number of visit limitations, and what requirements they may have to ensure payment (Rx, Letter of Medical Necessity, etc.).

2. **Co-payments and deductibles.** All co-payments and deductibles must be <u>paid at the time of service</u>. This arrangement is part of your contract with your insurance company. For your convenience we accept all major credit cards (Visa, American Express, Discover, MasterCard). We prefer to keep a credit card on file for weekly co-pays and/or weekly Therapy payments. By signing this Agreement you agree to allow Pediatric Speech Therapy of Forsyth to charge your card each week and/or each month to collect payment for services rendered.

3. **Non-covered services.** Please be aware that some, or perhaps all, of the services you receive may not be covered by your insurance carrier(s). Insurance carriers and their policies differ widely in terms of what Diagnoses and Procedures they will cover. We will work with you to help determine what your policy will cover but it is *your* responsibility to ensure that your policy will cover the specific Diagnosis provided for your child.

4. **Medicaid**. Medicaid pays for 8 units of Speech Therapy per month. This is equal to 8 (30 minute) sessions per month. Medicaid will pay for 8 units of Occupational Therapy per month. This is equal to 2 (1 hour) Occupational Therapy sessions per month. Speech Therapy of Forsyth will not apply for additional authorization for Medicaid but will only work with the given 8 units per month. Any non-covered procedures or services, or services provided over and above what Medicaid (or private insurance) will pay, is your responsibility.

5. **Proof of Insurance.** All patients must complete our Patient Information form before being seen by a Therapist. We must obtain a copy of your current valid insurance card 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. If you do not notify Pediatric Speech Therapy of Forsyth of a change or cancelation in insurance, you may be responsible for the balance of the claim if not paid by the insurance provider.

6. **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 ultimate 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 a party to that contract.

7. **Termination of Insurance.** In the event your insurance is terminated for any reason and we are not able to collect payment from your insurance provider, you will be responsible for payment in full for said unpaid claims. (*Attention all Medicaid, PeachState, Amerigroup and Wellcare patients:* – Medicaid and CMO policies terminate and are re-evaluated on a monthly basis – please be proactive and make sure your policy does not terminate and become inactive. Any claims submitted during the time your policy is *inactive* will result in the charges being billed directly to you.)

8. **Coverage Changes.** If your insurance changes, *please notify us before your next visit* so that we can make the appropriate changes to help you receive your maximum benefits. In the event you do not notify our office in a timely manner and your insurance has expired or becomes inactive for any reason, you will be responsible for any unpaid claims.

9. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless arrangements are made in advance with our office. Please be aware that if your balance remains unpaid, we may refer your account to a collection agency and your child may be discharged from our practice.

10. **Therapy Services.** Speech and Occupational Therapy is charged and billed by the hour. Speech Therapy rates for families paying out-of-pocket, for services not covered or due to loss of insurance is billed at $150 per hour. Occupational Therapy rates for families paying out-of-pocket, for services not covered or due to loss of insurance is billed at $120 per hour. These rates do not apply to Speech and Occupational Evaluations. Please discuss Evaluation rates with our Office Manager.

11. **Termination of Therapy.** Pediatric Speech Therapy of Forsyth, LLC reserves the right to suspend and/or terminate therapy at our discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, the patient's needs are outside of the therapist's scope of competence or practice, or the patient is not making adequate progress in therapy. The patient has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, the therapist will recommend that the patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. The therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to the patient.

12. **Release of Information.** By signing this Agreement, you agree to allow Pediatric Therapy of Forsyth, LLC Therapist(s) to discuss concerns, treatment, diagnosis and test results with collaborating health professional(s) {i.e. your child’s Pediatrician, other Therapists and/or any other health provider or teacher(s)} that may provide beneficial information to collaborate with and to assist your child’s Therapist in providing Therapy to your child.

13. **Photo Release**. By signing this Agreement, you agree to allow Pediatric Speech Therapy of Forsyth, LLC to take photo(s) of your child and display them within the clinic and/or our website. Said photos will not be used for sale nor would they be used for any other reason than as stated herein. If you decline to have your child’s photo taken or used as outlined here within, please initial below:
________ I do not want my child’s photo taken or placed within Pediatric Therapy of Forsyth, LLC or on its website.

14. **Supervision of Therapy.** Therapy provided to Pediatric Speech Therapy of Forsyth, LLC patients is supervised by Justine Glover, M.A. CCC-SLP, Clinical Director. Clinical Progress Notes and Evaluation Reports may be reviewed by Justine Glover on a case by case basis. In the event you would like to discuss your child's Pediatric Therapy with Justine Glover, she may be contacted by email jcglover7@gmail.com.

15. **IEP Disclosure/Wellcare/Medicaid/Amerigroup/PeachState .** If your child has an IEP from school, Medicaid and all CMO's require that we maintain a copy for disclosure. It is the responsibility of the parent/guardian that we maintain a copy of the most current IEP.

16. **Missed Appointments.** ***Our policy is to charge $50 for missed appointments not canceled before 12 hours of the scheduled appointment***. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointments, when possible.

Our practice is committed to providing your child with high quality therapeutic services to achieve your reasonable goals and objectives for your child. Our prices are representative of the usual and customary charges for Speech and/or Occupational Therapy services in our area. Thank you for understanding our payment policy and let us know if you have any questions or concerns.

I have read and understand all three pages of the Agreement of Services and Payment Policy and agree to abide by its guidelines. Further, I may request a copy of said Agreement to retain for my records.

Patient Name: ____

____ ______________________

Signature of Parent or Responsible Party **Date**