Pediatric Speech Therapy
(dba Speech Therapy of Forsyth, LLC)
4080 McGinnis Ferry Road - Building 300 Suite 302
Alpharetta, GA 30005
770-410-7719 OFC 770-410-9510 FAX

Buckhead/Midtown Location
Brookwood Exchange Building
1708 Peachtree Street NW
Suite 525
Atlanta, GA 30309

Norcross Affiliate Location
All Kids First – Connecting Dots
4720 Peachtree Industrial Blvd
Suite 305 and 301
Berkeley Lake, GA 30071

Updated 1/2017

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, UHC, Cigna 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, knowing your insurance benefits and limitations is your responsibility. 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.). See Disclaimer at the end of the Agreement.

2. **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. 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**. Currently, Medicaid allows for 8 units of Speech Therapy per month. This is equal to 8 sessions per month (our Therapists will treat your child for 30 minutes in addition to providing Speech Homework). Medicaid allows for 8 units of Occupational Therapy per month. Our Occupational Therapist will provide two (one hour) sessions per month in addition to providing Occupational Therapy Homework. Speech Therapy of Forsyth will not apply for additional authorization for Medicaid but will only work within the allowable 8 units per month as provided by Medicaid. Any non-covered procedures/services, or services requested over and above what Medicaid (or private insurance) will allow, is your responsibility. By signing this Agreement, you agree to allow Speech Therapy of Forsyth to bill Medicaid for Speech (and/or Occupational) Therapy services for therapy services rendered.

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 $160 per hour. Occupational Therapy rates for families paying out-of-pocket, for services not covered or due to loss of insurance is billed at $130 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 Speech 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. It is further granted by signing this Agreement, clients receiving services at All Kids First/Connecting Dots consent to allow collaboration, discussion of treatment and diagnosis. In addition you agree to allow sharing of pertinent Evaluation, Progress Reports and any and all documents required to facilitate therapy treatment.

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/Cancellation Policy.** ***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 NOTE:** We understand emergencies arise and will work with you under these circumstances. If your child becomes sick the morning of your Therapy appointment we ask that you contact your Therapist *immediately* so they are aware. More than ***two*** appointments not canceled within 12 hours due to sickness or other circumstance will result in a $50 charge on the 3rd cancellation.**
We reserve the right to charge $50 as and for an appointment not canceled within 12 hours.
Please help us to serve you better by keeping your scheduled appointments.

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 (in addition to the Disclaimer(s) below) 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

Release of Information. By signing above, you agree to Paragraph (12) of this Agreement wherein specifics are outlined with regard to sharing of information concerning treatment and collaboration.

Disclaimer

**Please Note: Speech Therapy is a service payable by time. If you have a thirty minute appointment scheduled and arrive late, your child's Speech Therapy session will be shortened (for example, if you arrive 10 minutes late for a 30 minute appointment, the Speech Therapy appointment will last 20 minutes but is billable for the full 30 minutes). Our Speech Pathologist frequently have an appointment scheduled immediately before and after your scheduled appointment time, therefore we ask that you respect your appointment time so they can best provide your child with the time they need for Therapy and to answer questions you may have. Our Speech Therapists will inform you of the length of the Therapy appointment. If you have an appointment conflict, please contact your Speech Therapist directly.*

Insurance Disclaimer: please understand the insurance information provided to you is not a guarantee of payment. Information provided is a courtesy and has been supplied to our office from ***your Insurance Carrier as of the date the information has been relayed*** *; however your insurance policy is a contract that we are not privy to and specific information about your coverage should be obtained directly from your Insurance Provider.*

Answers and benefit information provided by your Insurance Carrier is relayed to you. PLEASE be aware – this is not a guarantee of payment and policies are subject to change. In addition, if your Insurance Provider, for any reason, re-processes claims and/or requires a refund or reimbursement of payment from Speech Therapy of Forsyth, these charges will be the Member/Patient's responsibility.

Pediatric Speech Therapy, LLC
(dba Speech Therapy of Forsyth)
Alpharetta/Cumming Location

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PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment as listed below:

Pediatric Speech Therapy, LLC
dba Speech Therapy of Forsyth, LLC
Tax ID 20-2785721
4080 McGinnis Ferry Road
Building 300, Suite 302
Alpharetta, GA 30005

Buckhead/Midtown Location
1708 Peachtree Street NW
Atlanta, GA 30309

Gainesveille Location
Rubicon Lakefront Office Building
25665 Thompson Bridge Road
Suite 207
Gainesville, GA 30501

INSURED OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described:
Speech Therapy
and/or
Occupational Therapy

Patient/Member Name:_____

Siganture of Patient or Guardian of Patient:_____

Date: _____

HIPAA Disclosure Authorization Form

Patient Name: _____

I, as parent or legal guardian, hereby authorize **Pediatric Speech Therapy** (d.b.a. Speech Therapy of Forsyth, LLC) to use or disclose my child's protected health information related to Speech or Occupational Therapy to my (child's) insurance provider:
_____

I further authorize **Pediatric Speech Therapy** (d.b.a. Speech Therapy of Forsyth, LLC) to send insurance claims for Speech and/or Occupational Therapy services to my insurance carrier on my behalf or on behalf of my child.

- I understand that I may request to inspect or copy the protected health information described by this authorization.
- I understand that, at any time, this authorization may be revoked, when the office that receives this authorization receives written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.
- I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting it's confidentiality.

_____ _____

(Date) Signature of Individual (Parent or Guardian)

Relationship to Individual:

- ☐ Mother
- ☐ Father
- ☐ Guardian. Specify relationship:_____

EXPIRATION DATE: This authorization will expire on _____
If no date or event is stated, the expiration date will be six years from the date of this authorization.
COPY PROVIDED: The subject of this authorization shall receive a copy of this authorization if requested.

CREDIT CARD AUTHORIZATION
Authorization to Charge Credit Card

By signing below, I authorize Pediatric Speech Therapy (dba Speech Therapy of Forsyth, LLC), to charge my credit card for Speech and/or Occupational services for a period of one year from the date of the authorization.
This authorization further allows Pediatric Speech Therapy (dba Speech Therapy of Forsyth, LLC) to charge my card on a weekly or monthly basis for re-occurring Speech and/or Occupational services provides in accordance with the rates outlines in the previously signed Agreement of Services and Payment Policy.

In addition, this Release and Authorization allows my card to be charged $50 for missed appointments not canceled before 12 hours of the scheduled appointment as outlined in the previously signed Agreement of Services and Payment Policy.

Patient/Member Name:_____

Signature of Credit Card Holder:_____

Date: _____