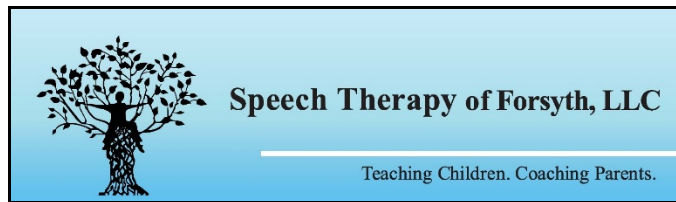


Speech Therapy of Forsyth, LLC
4080 McGinnis Ferry Road B300 Suite 302, Alpharetta, Georgia 30005
770-410-7719 OFC – 770-410-9510 Fax

# Agreement of Services, Release and Payment Policy

Updated 2/2021

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To ensure a smooth course and mutual understanding of our Therapy services and Financial Policy and Procedures, please review our policy and guidelines. A signed Agreement is required prior to your initial appointment or consultation.

1. ***Insurance***. We are participating with the following Insurance Providers: Aetna, Blue Cross, UHC, Cigna, Optum, American Specialty Health, Medicaid, Wellcare, Amerigroup, CareSource and PeachState. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with, payment in full for each visit may be required up front until we can verify insurance coverage. We will file primary insurance claims to your primary carrier if we are participating in your insurance benefit plan. We will file claims to Medicaid/Katie Beckett secondary carriers for your convenience, however, as required by Medicaid, we must be in-network with your Primary Insurance Provider and your child must have a pediatrician who is in-network with Medicaid. We will only file secondary claims to Medicaid from the date of receipt of the Medicaid card and will not re-file previously submitted claims for prior dates. Providing current insurance information is required. Knowing your insurance benefits and limitations is your responsibility. Please contact your insurance company with any questions you may have regarding coverage for Speech and Occupational Therapy, the diagnoses covered, number of visit limitations, and what requirements needed to ensure payment (authorization, Rx, Letter of Medical Necessity, etc.). See Disclaimer(s) at the end of the Agreement. *Please Note: Verification of coverage is not a guarantee of payment. Final determination of qualifying benefits are determined at the time the claim processing. All claims are subject to medical review and are subject to benefit maximums and other terms as outlined in your Member contract. In addition, if your Insurance Provider, for any reason, denies, re-processes claims and/or requires a refund or reimbursement of payment from Speech Therapy of Forsyth, LLC, these charges will be the Member/Patient responsibility. Benefits are subject to the terms of your Agreement with your Insurance Carrier and you (the Member/Responsible Party) are ultimately responsible for the services provided.*

2. ***Co-payments and deductibles.*** All co-payments, co-insurance 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 require ***a credit card on file*** for weekly co-pays and/or weekly Therapy payments. By signing this Agreement you agree to allow 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. It is agreed and understood that your insurance carrier may pay less than the actual bill for services. By signing this Agreement, you agree to be responsible for payment.

4. ***Medicaid***. Medicaid guidelines allow 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 Parent Coaching, a Home Program and written Speech Homework). Medicaid allows for 8 units of Occupational Therapy per month. Our Occupational Therapist may provide two hours of OT per month (equal to 8 units per month) in addition to providing Parent Coaching, a Home Program and written OT Homework. Due to our scheduling restraints, Speech Therapy of Forsyth is unable to and will not apply for additional authorization for Medicaid but will only work within the allowable 8 units per month as provided by Medicaid guidelines. Any non-covered procedures/services, or services requested over and above what Medicaid 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. **Medicaid Secondary Claims** (Katie Beckett, Deeming Waiver): We will only file current/active policy secondary claims to Medicaid. You are required to

inform our office at the time of signing this Agreement that you have an active Medicaid policy and provide proof thereof with a copy of your child's Medicaid card or letter from Medicaid. We reserve the right to refuse to submit claims to Medicaid as a secondary provider if we are not properly informed of an active policy at the commencement of therapy. Further, if you have applied for Medicaid after we have begun providing services, we will submit secondary claims beginning the date you have informed our office of the active policy, provided a copy of the Medicaid card *and* we have the required documentation on file as required by Medicaid. We reserve the right to NOT file secondary claims with Medicaid if, when you inform our office of a newly acquired policy, Medicaid pre-dated the effective date. (For example, if you receive notification of a newly obtained Medicaid policy, Medicaid may back-date the effective policy date. We will not submit claims to Medicaid as a secondary payer for the previous dates and will only submit secondary claims upon notification and proof of a current active policy in addition to having the required documentation Medicaid requires.)

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 and/or receive proof of current insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for payment of the services provided. If you do not notify Speech Therapy of Forsyth of a change or cancelation in insurance, you may be responsible for payment of the services provided if not paid by your insurance provider.

6. ***Claims Submission.*** We will submit your claims and assist, within reasonable means, to help get your claims processed. 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 payment for services provided 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. ***Claim Disputes and Appeals.*** Due to no fault of our office, often claims are incorrectly processed by your insurance provider and denied when therapy benefit(s) exist and have been verified on your plan. If we see a claim has denied and we believe the claim should have been covered based upon the benefit information provided to our office, we will recommend you contact your Insurance Provider to request they re-submit and re-process the claim according to the plan benefit. We may, as a courtesy, contact the Insurance Provider, to request a claim be re-submitted and re-processed according to the plan benefit. If the Insurance Provider refuses to pay, payment for the service is your responsibility. You have the option to dispute the charges directly with your insurance Provider. You may request that our office dispute the claim on your behalf and agree to a charge of $25 for each Date of Service. Disputing a charge is not a guarantee of payment and ultimately you are responsible for payment of services rendered. We will supply you with the information needed (to the best of our ability) so you may dispute the claim(s) directly with your Insurance Provider. If the claim(s) is further denied and you would like to exercise your option to Appeal, we will complete an Appeal of the claim at the rate of $50 per Date of Service. This Fee is in addition to the cost of the services provided. Please Note: This is not a guarantee of payment and ultimately you are responsible for payment of services rendered.

8. ***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, CareSource, Amerigroup and Wellcare patients:* –Any claims submitted during a time your policy is *inactive* will result in the charges being billed directly to you.)

9. ***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. If we are unable to obtain authorization, for any reason, you are responsible for services provided.

10. ***Nonpayment.*** If your account is over 90 days past due, you will be notified of the delinquency. 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 reserve the right to refer your account to a collection agency and your child may be discharged from our practice.

11. ***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.

12. ***Therapy Consultation Rates.*** Therapy is a service payable by time. We provide parent-coaching within the therapy sessions and is an integral part of therapy. Homework is provided at the end of our Therapy sessions allowing for parent communication and questions. Upon initial Evaluation and completion of a written Report, a 10 minute telephone conference is customary to discuss the Report and its findings (at no additional charge). Additional communication with a Therapist may be scheduled via telephone, video conference or in-person at the rate of $150/hour. Any additional time requested thereafter is payable by our Consultation Rate. At your request, Therapists may attend school meetings and/or other meetings and these services are available and payable at the Consultation Rate.

13. ***Termination of Therapy.*** Speech Therapy of Forsyth, LLC reserves the right to suspend and/or terminate therapy at our discretion. Reasons for termination may 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, not attending weekly therapy as recommended, not showing for a scheduled appointment or the patient is not making adequate progress in therapy. The patient has the right to terminate therapy at his/her discretion.

14. ***Release of Information*.** By signing this Agreement, you agree to allow Therapist(s) and/or employee(s) of Speech Therapy of Forsyth, LLC 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 information to collaborate with and to assist your child's Therapist in providing Therapy to your child. In addition you agree to allow sharing of pertinent Evaluation, Progress Reports and any and all documents required to facilitate therapy treatment.

15. ***Photo Release****.* By signing this Agreement, you agree to allow Speech Therapy of Forsyth, LLC to take photo(s) of your child and display them within the clinic, patient chart and/or our website. Said photos will not be used for sale nor 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 used as indicated above.

16. ***Supervision of Therapy.*** Therapy provided to Speech Therapy of Forsyth patients is supervised by Justine Glover, M.A. CCC-SLP, Clinical Director and/or Kari Sykes, M.A. CCC-SLP, Clinical Supervisor. Progress Notes and Evaluation Reports may be reviewed by Justine Glover and/or Kari Sykes on a regular 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.

17. ***IEP / IFSP Disclosure/Wellcare/Medicaid/Amerigroup/PeachState/CareSource* .** If your child has an IEP from school (or IFSP from Babies Can't Wait), Medicaid and all CMO's ***require*** we maintain a copy for disclosure. It is the responsibility of the parent/guardian that we maintain a copy of the **most current** IEP or IFSP. If a current IEP or IFSP is not provided, this may result in missed therapy sessions and/or the ability of insurance to pay for services provided.

*18.* ***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.

We reserve the right to charge $50 as and for an appointment not canceled within 12 hours. In addition, we reserve the right to remove your child's appointment from our Therapy Schedule if the appointment is canceled two times within a given month, if there is inconsistent weekly therapy attendance or for any other reason at our discretion.
We do not hold appointments if your child cannot attend Therapy. If you go out of town for more than one missed session or for any extended period, you may inform our office and re-schedule your appointments upon your return. We do not guarantee your previous appointment day and times will be available.

**NO SHOW** (Not attending an appointment without notice and/or proper cancellation).
Not Showing for a scheduled appointment will not be tolerated and will result in the removal from the Therapy Schedule

(at our discretion).
Patients insured thru a PeachCare for Kids or Medicaid Plan: Follow-up communication is required of your future therapy attendance intentions via email, voice mail or text to your Therapist within five days of the NO SHOW, a Discharge Report may be sent to your child's pediatrician and your child's insurance provider indicating therapy sessions have stopped.

***Please help us to serve you better by keeping your scheduled appointments.***

19. ***Parents/Guardians are required to remain on premise*** during child's Therapy session.
Parents/Guardians are required to remain on premise (i.e. within the parking lot) during their child's Speech and/or Occupational Therapy sessions.
In order to best utilize your child's scheduled Therapy time, PLEASE arrive to the clinic 5 minutes before the session is scheduled to start and return 5 minutes before the end of your child's therapy session is scheduled to end.

**Parents who do not return promptly or who return after the therapy session may be charged a fee of $50.**

20. ***Release of Information*.** By signing below, you agree to Paragraph (14) of this Agreement with regard to sharing of information concerning treatment and collaboration (Paragraph 14 of Agreement hereto).
You may decline (decline authorization to allow collaboration as indicated in paragraph (14) of Agreement hereto) by printing your name and checking the box below.

☐ By checking this box, I decline and DO NOT ALLOW any collaboration and or conversation between my child's Speech and/or Occupational therapist with any and all healthcare professionals or teachers outside of Speech Therapy of Forsyth, LLC. __________________________ (parent/guardian printed name required)

By signing this Agreement, you confirm you are aware and have read the following additional policy guidelines:

*Additional Insurance Policy:*
- If your child is receiving Therapy services anywhere else you must notify us prior to starting services. Most commercial plans will allow an evaluation once every 6 months. If you request an evaluation or re-evaluation prior to the allowed timeline and your insurance denies payment, you will be responsible for payment of services.

- Should you have any questions regarding your insurance coverage or any financial questions, do not discuss or direct those to your child's Therapist or any other Therapist. They do not have the knowledge or requirements to provide that information. Please contact our office 770-410-7719.

- If your child has Medicaid, Wellcare, Peachstate Health Plan, Amerigroup or Caresource: Only 1 authorization is allowed per authorization period. Medicaid and CMO's will not provide authorizations for th same services to different therapists or practices at the same time. Not providing us with that information will result in you being billed for any non-covered or denied services.

- If your insurance and/or Medicaid, Wellcare, Peachstate Health Plan, Caresource or Amerigroup policies deny payment due to services being provided with another therapist/practice, you will be liable for those charges.

*Additional Communication Policy:*
- If you need to change/cancel your child's appointment, contact your child's Therapist directly.

- For the purpose of communication, our Therapist's provide you with their cell phone numbers, it is often easier and faster to return a text than it is to return a phone call.

- Please be respectful of the Therapist's personal time and only contact them on their cell phone ***during business hours***. You may email your child's Therapist at any time. Texts and emails are normally returned the following business day. Any additional concerns may be directed to our front office staff by calling 770-410-7719

- The Therapist will contact only one parent regarding schedule changes and basic information. It is the parent's responsibility to communicate with each other.

Our practice is committed to providing your child with high quality therapeutic services to achieve appropriate, 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.

**By signing below, I confirm I have read and understand all five pages of the Agreement of Services, Release and Payment Policy and agree to abide by its terms.**
**Further, I am aware I may request a printed copy of said Agreement to retain for my records.**

**Patient Name:** ______________________________________________

______________________________ ______________________
**Signature of Parent or Responsible Party** **Date**

**Speech Therapy of Forsyth, LLC**
**Alpharetta/Cumming Location**

**770-410-7719 OFC 770-410-9510 FAX**

**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE** I authorize the release of any medical or other information necessary to process claims. I authorize payment of medical benefits to the undersigned provider for Speech and/or Occupational Therapy services provided.
I also request payment of government benefits either to myself or to the party who accepts assignment as listed below:

Speech Therapy of Forsyth, LLC
Tax ID 20-2785721 NPI 215909163

4080 McGinnis Ferry Road
Building 300, Suite 302
Alpharetta, GA 30005

**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***

This authorization is valid from today's date as indicated below until such time as services are no longer rendered by Speech Therapy of Forsyth, LLC or its rendering providers.

Patient/Member Name: ___________________________________________________________________________

Signature of Patient or Authorized Person/Parent/Guardian of Patient:_____________________________________

Date: ______________________________

# HIPAA Disclosure Authorization Form

Patient Name: ______________________________________________________________

I, as parent authorized or legal guardian, hereby authorize **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 **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.

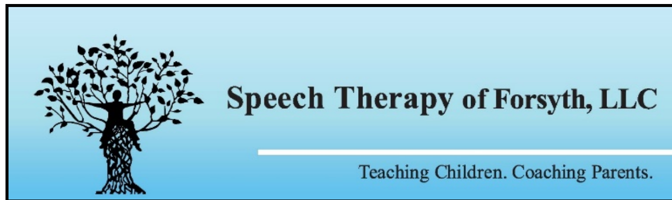
______________ ________________________________________________________

(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: Upon request - the subject of this authorization may receive a copy of this authorization.




# CREDIT CARD AUTHORIZATION
## Authorization to Charge Credit Card

By signing below, I authorize Speech Therapy of Forsyth, LLC, to charge my credit card for Speech and/or Occupational services.

This authorization further allows 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 or as outlined in paragraph (18) (19) of the signed Agreement of Services, Release and Payment Policy.

Patient/Member Name:____________________________________________________

Signature of Credit Card Holder:______________________________________________

Date: ____________________________________________________________________