

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 2/2022

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, 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.). Disclaimer(s) *Please Note: Verification of coverage is not a guarantee of payment. Final determination of qualifying benefits are determined at the time of 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 may or may not cover. It is agreed and understood that your insurance carrier may pay less than the actual bill for services. An estimate of the charges for services is provided to you prior to the initial appointment. By signing this Agreement, you agree to be responsible for payment of covered and non-covered services.

**NOTE:** Your Insurance provider may deny payment of services provided within an Evaluation or Therapy; and, may consider the service or, a portion thereof, as experimental, investigational or unproven for a given diagnosis. Example of (possible) non-covered charges: your Child's Evaluation may include a Sensory Integration assessment and, if weekly Therapy is recommended, therapy provided for sensory integration may be recommended and included but not covered by Insurance. Prior to your Child's Evaluation and Therapy you will be provided with the Evaluation and Therapy charges for said services. You may choose to decline services for Sensory Integration within the Evaluation and weekly Therapy.

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 cancellation 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.** It has been our experience that claims are often incorrectly processed by your insurance provider and denied when therapy benefit(s) exist and have been previously verified on your plan. If we see a claim has been 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 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 as soon as possible 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 60 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 \$200 per hour. Occupational Therapy rates for families paying out-of-pocket, for services not covered or due to loss of insurance is billed at \$140 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. We reserve the last 5 minutes of the session for parent conversation and add parent coaching. 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.

You may choose to DECLINE (decline authorization to allow collaboration as indicated in paragraph (14) of Agreement hereto) by checking the box and printing your name on the line 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)

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. You may 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 are often reviewed by Justine Glover and/or Kari Sykes, and for OT Dana Oh OTR OT Supervisor. 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](mailto:jcglover7@gmail.com).

17. **IEP / IFSP Disclosure: 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 unforeseen situations 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). New Patient Evaluations – we will not re-schedule an Evaluation due to a NO SHOW.

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 our office or 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 for every 15 minutes.**

**20. Email Correspondence and Email Consent:** Email is used as a means of communication information. RE: appointments and other information. At your request, we will use email as a means of communicating and sending Therapy reports or other clinical documents but will require an executed EMAIL CONSENT release. The EMAIL CONSENT is an acknowledgement of your recognition and understanding of the inherent risks of communicating your child's health information via unencrypted email and consent to receive such communications despite those risks. The Email Consent further states that you have the choice to receive communications via other more secure means such as by telephone. At your request, we will provide one printed copy of your child's Therapy Report at no charge to you (Reports include: Speech Evaluation Report, Speech RE-Evaluation Report, Occupational Therapy Evaluation Report or Occupational Therapy RE-Evaluation Report). The Report will be available for pick-up at the location address: 4080 McGinnis Ferry Road, S302, Alpharetta, GA 30005. Additional printed copies are available for a fee of \$0.25 per page.

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

*Additional Financial Policy:*

**-CREDIT CARD:** There is a **\$10 charge for CREDIT CARDS THAT ARE DECLINED.** It is the Member/Parent responsibility to assure our office has a current card on file with sufficient funds to cover services.

A Credit Card, Debit Card or HSA Card are required to be kept on file for all client accounts, regardless of your child's insurance coverage.

By signing this Agreement, you agree that your card may be charged for services NOT covered by Insurance. Example of charges: arriving late to pick-up to receive your child from Therapy (\$50 for every 15 minutes after the end of session time); charges for services that occur if your child's insurance has been terminated and not payable by insurance; \$10 for credit cards that are declined; in addition to any other charges as stated within this Agreement.

- 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, Peachstate Health Plan, Amerigroup or Caresource: Only 1 authorization is allowed per authorization period. Medicaid and CMO's will not provide authorizations for the same services to different therapists, provides 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, 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.

**Therapy Notes:**

-You may request copies of the notes via email. Please contact the office to be provided with the email. 770-410-7719

-Request for notes are reviewed and may be delivered within 3-7 business days via email (upon executed EMAIL consent).

-Printed copy of notes may be requested at a fee of \$0.25 per page. Payment is required prior to printing and notes available within 3-7 business days for pick up at our clinic. 4080 McGinnis Ferry Rd Building 300, Ste 302 Alpharetta, GA 30005

**Mailing Notes:**

-Additional fee to be determined. Covers packaging and the cost of mailing.

**Additional Communication Policy:**

- If you need to change/cancel your child's appointment, contact your child's Therapist directly. You are provided with your therapist contact information via email at the start of therapy session

- 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.

-Therapy notes will only be provided to one parent (the Parent who has signed this Agreement/Responsible party).

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.**

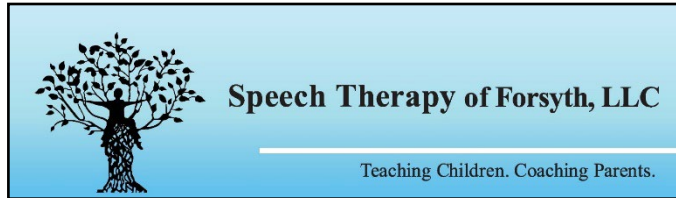
**Patient Name:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Parent or Responsible Party**

\_\_\_\_\_  
**Date**

**Relationship to Patient:** \_\_\_\_\_

(i.e. Mother-Father-Legal Guardian)



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**Speech Therapy of Forsyth, LLC**

Alpharetta/Cumming Location

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

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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 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: \_\_\_\_\_





Speech Therapy of Forsyth, LLC  
4080 McGinnis Ferry Road - Building 300 Suite 302  
Alpharetta, GA 30005  
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## **EMAIL COMMUNICATION OF HEALTH INFORMATION FACT SHEET AND CONSENT FORM**

As a Parent of a patient receiving therapy services with Speech Therapy of Forsyth, LLC, you may request that we communicate with you via unencrypted electronic mail (email).

This Fact Sheet will inform you of the risks of communicating with your healthcare provider via email. Your health is important to us and we will make every effort to reasonably comply with your request to receive communications via email, however, we reserve the right to deny any request for email communications when it is determined that granting such a request would not be in your and our best interest.

### **PLEASE READ THIS INFORMATION CAREFULLY**

Speech Therapy of Forsyth, LLC staff will make every effort to respond to your requests for information via email, however, if you are experiencing an emergency, you should never rely on email communications and should seek immediate medical attention.

### ***Risks of using email to send protected health information include, but are not limited, to:***

**Risk of Unauthorized Access by a 3rd Party:** Do you share a computer with your family? Is your email address or access to email provided through your employer? Do you access your email over an unsecured connection such as public Wi-Fi? Do you access your email on your mobile device? Emails may be accessed by someone you do not wish to know about your child's health information. Despite necessary precautions, email may be sent to the wrong address by either party. Email may be intercepted or altered in transmission by a computer hacker or computer virus.

**Unique Difficulty in Verifying the Sender:** Email may be easier to forge than handwritten or signed papers. Speech Therapy of Forsyth, LLC will send emails to the email address you provide, but it may be difficult to confirm that you are in fact the person sending the request for information from your email address. It is rare, but not impossible, that human error may allow for an incorrect email address to be transcribed. When you Consent to receiving email correspondence and Therapy Reports via email, you assume the risks caused by human error.

### **Procedures**

Emails are not checked outside of normal business hours – this includes overnight, on weekends or holidays. If at any time you change your email address or wish to discontinue email communications altogether, you must notify Speech Therapy of Forsyth, LLC immediately in writing. Email communication is acceptable and a email response will be provided acknowledging the change.



**PATIENT CONSENT TO UNENCRYPTED EMAIL COMMUNICATIONS**

Name of Patient (Child): \_\_\_\_\_ DOB: \_\_\_\_\_

By signing below, you acknowledge your recognition and understanding of the inherent risks of communicating your child's health information via unencrypted email and hereby consent to receive such communications despite those risks. Messages containing clinically relevant information, and/or Therapy or other Reports may be incorporated into the medical record at the provider's discretion.

By signing below, you also acknowledge that you have the choice to receive communications via other more secure means such as by telephone.

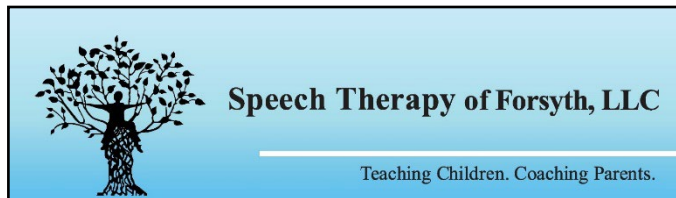
At your request, we will provide one printed copy of your child's Therapy Report at no charge to you (Reports include: Speech Evaluation Report, Speech RE-Evaluation Report, Occupational Therapy Evaluation Report or Occupational Therapy RE-Evaluation Report).

The Report will be available for pick-up at the location address: 4080 McGinnis Ferry Road, S302, Alpharetta, GA 30005. Additional printed copies are available for a fee of \$0.25 per page.

By signing below, you agree to hold Speech Therapy of Forsyth, LLC harmless for unauthorized use, disclosure, or access of your child's protected health information sent to the email address you provide.

Parent Email Address: \_\_\_\_\_

Parent Signature \_\_\_\_\_



**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-going, on a weekly or monthly basis for re-occurring Speech and/or Occupational services provided in accordance with the rates outlined 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; for arriving late to pick-up my child from Therapy, \$10 for credit card declined; in addition to any other charges as stated within the Agreement.

Patient/Member Name: \_\_\_\_\_

Signature of Credit Card Holder: \_\_\_\_\_

Date: \_\_\_\_\_

Payment is required at the time services are rendered.

Credit cards are generally charged on Friday or Saturday for services provided the previous week (holiday weeks may differ).