Speech Adult Contract

The intake paperwork will take approximately 25-30 minutes for completion.
Please complete all sections prior to your first appointment.
Thank you for being a part of Speech For Success, PLLC.

**** indicates a required field***

Session

Private health insurance will be billed as my primary means of payment. If claims are denied as a result of changes/limitations in insurance coverage benefits, the private pay rate of $90 per session will be charged. I acknowledge that I am responsible for understanding my own insurance plan and the speech therapy/occupational therapy benefits that it provides (including benefit limitations, benefit maximums, deductibles, coinsurance, and copayments}.

Speech for Success, LLC will not be held responsible for interpreting the benefit information for me. Speech for Success, LLC is also not responsible for the determination of payment or denial by my insurance carrier. The responsibility of Speech for Success, LLC is to collect deductibles, co-payments, co-insurance payments, and/or the cost of denied claims. I am responsible for these payments at the time of my visit. It is also my responsibility to notify Speech for Success, LLC immediately of any changes in my health insurance plan. If Speech for Success, LLC is not notified of changes in my insurance plan, I may be subject to charges resulting from denied claims.

*** If I am unable to attend a speech therapy/OT session, I agree to contact Speech for Success, LL/Clear Speech Inc. at least 24 hours in advance at (425) 405-0837 or by email. If I fail to provide 24 hours notice for a cancelled session, I understand that a fee of $90.00 will be charged to my account (with the exception of emergencies, and inclement weather).**

I understand that insurance cannot be billed for this "no-show" fee and the fee is non-negotiable. I am responsible for paying cancellation fees at my next scheduled appointment.

I will notify the owners at the next scheduled appointment if I am in need of a payment plan.

Please sign above

I consent to sharing information provided here.

If the clinician needs to cancel your session due to an illness or emergency, we will notify you as soon as possible. If a cancellation is necessary for any reason other than illness (e.g., conference, vacation, etc.), you will be notified in advance and we will make our best efforts to reschedule your appointment.

Our staff will notify you with a phone call in the event that we must cancel your session due to inclement weather conditions (We will offer Telehealth first). If you are unsure as to whether or not Speech for Success, LLC/Clear Speech Inc. is open, please call the office at (425) 405-0837. At which point, if you feel uncomfortable traveling to our clinic you may request a telehealth session. You can also follow our business page on Facebook for updates on closings due to weather.

I understand that consistent attendance plays an important role in maintaining my skills or in therapy and preventing regression of skills. As such, I agree to make my best effort to attend the scheduled sessions on a regular basis. I understand that sessions are scheduled for each client on the same day and time each week. I will only accept a time slot if I am able to attend that day/time on a weekly basis. I understand that Speech for Success, LLC does not offer appointments every-other week or on a monthly basis.

I acknowledge and agree to each of the following attendance policies:

• Clients who miss three (3) consecutive sessions (with the exception of serious illnesses or emergencies) will be notified that they are in jeopardy of losing their appointment slot, and it may be given to someone else.

• Clients who miss two (2) consecutive sessions without calling us 24 hours in advance to cancel the sessions (with the exception of serious illnesses or emergencies) will be removed from their appointment slot and charged with cancellation fees for those sessions.

• Clients who miss a total of three (3) consecutive or non-consecutive sessions will be removed from their appointment slot, transitioned to waitlist and charged with cancellation fees for those sessions. Please notify us in advance if you plan to go on a vacation and will be absent for two (2) or more weeks, so that efforts can be made to reschedule your appointments.

If you are late to an appointment, the session will need to conclude at the usual time to allow the clinician to stay on schedule. If the clinician is running late for any reason, you will be given the full session time. Our staff regrets any inconvenience to your personal schedule, and we will make our best efforts to maintain timeliness.

Cell phones: Please do not have your cell phone out during the therapy session. If you would like to take pictures, please ask permission from your therapist prior to taking pictures. We do not allow video footage to be taken on personal cell phones. Thank you for respecting this policy.

Holiday Closures

The office will be closed for the following holidays:

• New Year's Day
• Presidents' Day
• Memorial Day
• Fourth of July
• Labor Day
• Thanksgiving and the Friday following
• Christmas Eve and Christmas Day

If you are unsure if we will be open or closed during a particular holiday, please call us or check our website for more information.

The following reasons are grounds for immediate termination of your client contract:

• Non-compliance with our attendance policy.

• Repeatedly not paying an account. You will receive a warning when there is an outstanding account balance with multiple payments due. If we do not receive your payment within 2-weeks upon receipt of that warning, therapy will be placed on hold until payments are rendered in full. You may lose your appointment slot and be placed on a waiting list at that time. Continued non-payments will result in termination of services.

• Engaging in behavior that breaches trust such as withholding pertinent information about the case history or asking us to alter our data or diagnosis. If you need to terminate therapy for any reason, we ask that you give us written notice a minimum of two (2) sessions in advance. This will allow us adequate time to wrap-up therapy and complete consultation with you. A therapy termination form will be provided for you to complete.

Speech for Success LLC, reserves the right to cancel or amend this contract, or any part therein without negating the remainder of the contract. Clients will be notified, in writing, of any changes or cancellation of this contract.

Refunds will only be provided electronically through the Simple Practice Portal to the account credit card on file.

No Surprises Act

Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to provide a good faith estimate of expected charges for items and services to individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing, upon request or at the time of scheduling health care items and services.

The Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created, and does not include any unknown or unexpected costs that may arise during treatment.

If you are planning to pay for services privately, you will receive an additional form for the “No Surprises Act.”

I consent for a reevaluation to be performed Quarterly and/or Yearly to assess progress and or needs to modify or change my treatment plan.

Please sign above

I consent to sharing information provided here.

Telehealth

1. I understand that my health care provider may wish me to engage in Telehealth at some point due to illness or scheduling needs.
2. My health care provider explained to me how the video conferencing technology that will be used will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, vand technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH BY SIMPLEPRACTICE SERVICE

Telehealth by SimplePractice is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by SimplePractice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice Service - or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Please sign above

I am agreeing that I have read, understood and agree to the items contained in this document.

Financial Policies

Thank you for choosing us for your care needs. We are committed to providing you with the best possible care. The following is a statement of our appointment and financial policies which we require you to read and sign prior to your treatment.

Our Responsibility

To accurately and efficiently bill you according to services rendered.
To assist you in resolving any problems with claim payment.

Your Responsibility

To pay for any and all cash services at time of visit. To provide us with accurate information to submit your claims correctly, including copies of your insurance card(s) and photo ID. To pay your copay at the time of service. We accept Cash, Check, Credit/Debit Card, and CareCredit. No Post-Dated or Third-Party Checks. All returned and NSF checks will result in a $35.00 fee. Complete a credit card preauthorization form and present a credit card, Health Savings or Flexible Spending card to be encrypted for automatic payment of cash services, remaining co pay, coinsurance, deductible balances when they become due on your account as determined by your insurance plan or cash services.

** Speech For Success, PLLC/Clear Speech runs payment for all copay/coinsurance/deductibles within two weeks of appointments or immediately after insurance finalizes claims.**

Appointment Policy

A scheduled appointment is a commitment of time between the therapists and patient. We have reserved time just for you. When appointments are missed or canceled with short notice, that time is lost. When you've made an appointment, we request you make every effort to keep that appointment. We understand that emergencies do arise, but reserve the right to charge no show or late cancellation fees for all missed or late cancelled appointments.

In the event that an additional session spot opens during the week outside of your normal scheduled time; which office location would you prefer? Circle one.

Everett Marysville Mukilteo Any

Referrals / Authorizations

Some insurance plans require your primary care provider to obtain a referral authorization number from the insurance company for you to see us. A referral requirement is the result of your contract with your insurance company, so it is ultimately your responsibility to ensure that it has been done. If your insurance company denies payment because a referral has not been obtained, you will be responsible for the cost of the visit. We allow up to 30 days for insurance to reimburse for services. If insurance does not pay within 30 days after request, you are required to pay remaining balance until your insurance has covered all submitted claims. We will collaborate with you to get the original referral. You are responsible for any balances classified as 'Patient Responsibility' by your insurance company. Any dispute with claim processing is between you and your insurance company.

Payment Arrangements

Cash Patients Payment is due in full at time of service. Insurance Patients: Once your insurance processes your claim, a copy of the EOB (Explanation of Benefits) will be issued to you by your insurance.

Speech For Success, LLC/Clear Speech, Inc will upload a patient invoice for balance due based off your finalized claim. In an effort to be more environmentally conscious and earth friendly we provide electronic statements. You may mail a check, or pay in person, or pay online, or allow the balance to be charged to your credit card on file. Invoices are sent within 24 hrs. SFS/CS will process the balance due to your credit card on file. If your card is declined or has expired, a second statement will be sent. Accounts not paid within 14 days of the second statement become past due and may incur a one-time $35.00 Collection Fee.

The Collection Fee will be applied to your account. All accounts over 60-Days without an approved payment plan are subject to further action which may be reported to the credit agencies. Past Due Account balances must be settled prior to making or being seen for a subsequent appointment.

Patient / Guardian / Parent Responsibility

The parent(s) or guardian(s) accompanying a minor is responsible for providing current insurance information for the minor as well as the payment for services provided. At the initial visit you may sign our consent for minor treatment form that allows us to render care at follow up visits without the presence of a parent or guardian. SFS/CS does not bill absent parents for payments due at the time of service.
The adult presenting the minor for care is the responsible party.

Services Considered Non-Covered by Insurance

No Shows Late Cancels Out Of Network-May be subject to higher deductibles and or no contractual provider discounts OUT OF NETWORK*Check your coverage carefully and make sure you understand their answers. It is your responsibility to determine reimbursement eligibility.

Collection Policy

I understand I will be charged for, and hereby agree to pay, all costs and expenses incurred in collecting any past due fees, and interest allowed by law, all without relief from valuation and appraisement laws. All unpaid accounts, regardless of size, are turned over to Physician's & Dentists Credit Bureau or pursued in small claims court. Returned Checks and Chargebacks: All returned checks will be subject to a $75 returned check fee. If the check is returned for any reason, you have 7 days to contact the office and arrange another form of payment. Credit Card chargebacks will be subject to a $75 administrative fee, in addition to any other bank fees that are assessed. SFS/CS has a collection policy in place for delinquent accounts. If we have been unable to obtain payment in full or maintain scheduled payment arrangements from you after 120 days of repeated attempts, the account will be turned over to our collection agency and you will be discharged from the practice. Patients who are discharged from SFS/CS due to non-payment may request a copy of their medical records be sent to the health care provider of their choice in order to continue care.

Assignment

I authorize payment to be made directly to Speech for Success, LLC / Clear Speech, Inc by my insurance company, and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical care information requested by my insurance company. I authorize the use of my signature below on all my insurance submissions whether manual or electronic.

Credit Card Authorization

I consent to keeping a credit card on file with Speech for Success, LLC / Clear Speech, Inc to be used for all unpaid balances for services rendered now and in the future. I authorize Speech for Success, LLC to charge my card in full for any outstanding balances. If billed to Insurance, Charges will only be made after the claim has been adjudicated by the insurance carrier. A credit card is required of all patients receiving services at Speech For Success, PLLC / Clear Speech Inc. All individuals with Washington State insurance plans are excluded. I understand payments for Self-Pay and/or Non-covered services are due at the time of the office visit and give permission for these charges to be placed on my credit card on file. I am aware of the late show and late cancellation policy and give permission for these charges to be placed on my credit card on file. Speech for Success requires all clients to keep a credit card on file.

Acknowledgement

I certify that I have read the financial and appointment policies of Speech For Success, LLC / Clear Speech, Inc and I agree to abide by these policies.

Please sign above

I consent to sharing information provided here.