



Speech Therapy Works: Rules and Responsibilities

Statement of Understanding

Thank you for selecting *Speech Therapy Works* as your provider for speech and language therapy services. The policies described herein have been carefully reviewed in an effort to provide exceptional, patient-centered speech and language evaluation and treatment services. The purpose of this contract is to identify and explain the expectations and duties of the Speech-Language Pathologist, patient, and/or patient's parties for speech and language therapy services.

Speech Therapy Works and _____(name) hereby agree to the terms set forth below. I, _____(name), hereby consent for *Speech Therapy Works* to provide speech and language evaluation and/or treatment services to: _____(patient's name). I understand that this agreement may be terminated by either party, in writing, at any time.

Speech and language therapy services at *Speech Therapy Works* are provided by Nicole Bishop, M.A., CCC-SLP, a licensed Speech and Language Pathologist in the state of Texas. Nicole holds a current Certificate of Clinical Competence (CCC) issued by the American Speech-Language-Hearing Association (ASHA). She is also a member of the Texas Speech-Language-Hearing Association (TSHA).

- *Speech Therapy Works* will not be held responsible for any claims or damages of any kind, including (but not limited to): injury to any person or persons and/or damage secondary to property loss deriving directly or indirectly from participation in evaluation and/or treatment sessions.
- All patient information will be kept confidential at all times. Information will be kept in a secure location free from public access.

Billing/Fees for Services:

The following is the current Fee Schedule and Payment Policy for speech and language therapy services to be provided by Nicole Bishop, M.A., CCC-SLP on behalf of *Speech Therapy Works*. All fees and costs shall be due at the time that services are rendered and payable in accordance with the Agreement to Terms of Payment. The patient/guarantor is responsible for the payment of services and agrees to comply with the established, current fee schedule. *Speech Therapy Works* reserves the right to modify the fees stated below. You will receive thirty (30) days of advanced notification of any alteration in service fees.

Fee Schedule

Evaluation	\$285
Individual/Group Treatment	\$120

Individual evaluations consist of the following components: formal/informal assessment measure(s), scoring analyses, interpretation, report writing, and consultation. The length of evaluations is typically 90 minutes, but may vary according to the patient's needs. Individual and group treatment sessions consist of 40 minutes of direct treatment and 5 minutes of consultation.

I, _____ (name) understand that I must establish an advanced arrangement with *Speech Therapy Works*, in the event that I would like to submit claims to my insurance company. It is my responsibility to coordinate insurance reimbursement. If requested in advance, *Speech Therapy Works* will provide me with a monthly billing statement that will include the necessary documentation to submit claims to my insurance company (e.g. diagnosis and procedure codes, dates of service, and the facility's tax identification number).

I, _____ (name) understand that I am solely responsible for understanding my own insurance plan and submitting claims to my insurance company in the event that I wish to request reimbursement for services rendered by *Speech Therapy Works*. I understand that *Speech Therapy Works* is not responsible for the determination of payment or denial of services by my insurance company.

Cancellation Policy:

Speech Therapy Works requests 24 hours advance notification in the event that your child is unable to attend his or her appointment. Cancellations made less than 24 hours prior to a designated appointment, "no calls," and/or "no shows" will be billed for the treatment session missed and the invoice will appropriately reflect this information. Please contact our office manager, Patty, at (832) 292-6800 to leave a detailed message in the event that a cancellation is deemed necessary. Chronic cancellation of appointments can and will lead to discharge of services from *Speech Therapy Works*.

I, _____ (name) understand that if my child is unable to attend an evaluation and/or treatment session, I agree to contact *Speech Therapy Works* at least 24 hours in advance at (832) 292-6800. If I fail to provide 24 hours of advanced notification for a canceled session, I, _____ (name) understand that a fee of \$50.00 will be charged to my account (with the exception of illnesses, emergencies, and inclement weather). I understand that this fee is non-negotiable and cannot be billed to my insurance company.

Speech Therapy Works is committed to providing your child with high quality therapeutic services to promote the most optimal plan of care. Please assist in maintaining your child's scheduled speech therapy appointments. If *Speech Therapy Works* is unable to complete a scheduled evaluation and/or treatment session for any reason, we will notify you as soon as possible. *Speech Therapy Works* will attempt to schedule a make-up session.

Authorization for Credit Card Use:

By signing below, you confirm that you fully understand that health insurance policies and reimbursement are between you and your health insurance company. By signing below, you confirm that all services rendered to your child are charged directly to you, and that you are personally responsible for services rendered at *Speech Therapy Works*. By signing below, you confirm that this financial responsibility is not related to potential health insurance coverage or reimbursement. The undersigned authorizes *Speech Therapy Works* to make the following charges to his or her credit card for payment of speech and language evaluation and/or treatment services rendered, as well as any associated expenses.

CREDIT CARD TYPE: ____ Visa ____ MasterCard ____ Discover

CREDIT CARD NUMBER: _____

EXPIRATION DATE: _____ 3 DIGIT CODE: _____

NAME (as it appears) ON THE CARD: _____

ADDRESS THE CARD STATEMENTS ARE MAILED TO (BILLING ADDRESS):

ZIP CODE of BILLING ADDRESS: _____

SIGNATURE OF CARD HOLDER: _____

EXPIRATION DATE: _____

This information must match the card or it will not process. We request that you notify our office as soon as possible if any of this information changes. This agreement will remain in effect until this agreement is canceled in writing.

The following forms of payment will be accepted: cash, check (made payable to *Speech Therapy Works*), or credit card (Visa, MasterCard, and Discover). A **\$25 fee** will be applied to all bounced checks. Payment is due at the time that services are rendered.

Termination of Therapy/Refusal of Services: *Speech Therapy Works* reserves the right to suspend and/or terminate therapy at any time, at our discretion. Reasons for termination include, but are not limited to: untimely payment of fees, failure to comply with treatment recommendations and/or a recommended home program, conflicts of interest, failure to fully participate in therapy, lack of adherence to the facility's attendance policy, and/or lack of adequate progress in therapy. The patient/parent(s)/caregiver(s) have the right to discontinue therapy services. We reserve the right to refuse evaluation and/or treatment services to any individual(s) at our sole discretion, secondary to behavioral concerns, lack of compliance with clinic policies, or any other complications that we feel may affect the safety and/or wellbeing of our staff and/or clientele.

Appointments: Your appointment is a reservation for professional time reserved exclusively for your child. *Speech Therapy Works* strives to remain on schedule and appointments are not overbooked. However, please know that there may be circumstances that could result in a delay in starting your appointment. Should this occur, *Speech Therapy Works* sincerely apologizes in advance and truly appreciates your patience and understanding in this matter.

Late Arrivals: Please strive to arrive on time for your child's appointment. *Speech Therapy Works* cannot impose on the next patient's appointment, secondary to a late arrival to a scheduled speech and language evaluation and/or treatment session. Unfortunately, patients who arrive late may not be seen for a full session or may be asked to reschedule the session.

Safety: For your safety, *Speech Therapy Works* requests that a parent and/or assigned guardian remain in the building for the duration of your child's speech therapy session. All family members and friends may remain in the waiting room and/or "play room" with a designated adult while your child participates in evaluation or treatment session. Pets are not allowed inside of the facility, secondary to safety concerns and regulations.

Terms and Conditions:

I read, understand, and agree to the policies outlined above. My signature below indicates that I consent to all terms, rules, and regulations of *Speech Therapy Works*.

Client (Child) Name: _____

Parent/Caregiver Signature: _____

Date: _____

No delay or omission by either party to enforce or exercise any right, remedy or power under this Agreement shall be construed as a waiver of such right, remedy, or power. A waiver by either party of any breach or default under the terms of this Agreement shall not constitute a waiver of any subsequent breach or default. In the event any provision of this agreement is held to be unenforceable by a court of competent jurisdiction, the remainder of the Agreement shall remain in full force and effect. In the event of litigation arising out of this Agreement, the prevailing party in such litigation shall be entitled to payment of its reasonable attorney's fees and costs from the other party. Nor right or remedy herein conferred or preserved in this Agreement is exclusive of any right or remedy provided or permitted at law or in equity, but each shall be cumulative of every other right or remedy given hereunder now or hereafter existing at law or in equity, by statute or otherwise, and may be enforced concurrently therewith or from time to time. This Agreement is made in and shall be enforced in the State of Texas. Any and all actions arising from this Agreement shall be brought and maintained in Fort Bend County, Texas.