SpeechPath Outpatient Clinic

Policies and Procedures

Welcome to SpeechPath Outpatient Clinic. Our licensed therapists offer speech/language and occupational therapy, evaluations, and consultations. Services offered are comprehensive and can include collaboration/consultation with teachers and school administrators, physicians and other professionals.

FEES/PAYMENT

The cost of therapy, is provided on our rate scale attached. Therapy is provided in 15 minute increments from 30 minutes up to 1 hour of service, depending on the individual need. Evaluations are billed at varying rates according to the type of evaluation performed. Estimates of the cost will be shared with you before the evaluation is scheduled. If you do not request a formal evaluation with a written report, consideration will be given to providing a period of diagnostic therapy instead. Outside evaluations are accepted if they are recent enough for us to develop a treatment plan. A fee will be charged for additional services such as a re-evaluation, a re-evaluation report, progress notes, an extensive progress report, conferences, phone calls to other professionals, etc. Attendance at (IEP) meetings as well as off site observations, are billed at the regular rate. You may choose for those services to occur during your regularly scheduled session, but please be aware that insurance may not cover all such services.

_____(Initial)

Payment is due upon receipt of services. Please make every effort to abide by this policy. If you prefer to pay once a month, payment must be made upon receipt of your statement. Statements are provided by electronic means through your e-mail unless specifically requested otherwise. If you are receiving more than one service, please write on the check which service is to be credited what amount. Returned checks will be assessed a $15 processing fee. Statements are printed at the end of each month. If you should have an unexpected overdue balance, you will be asked to make payment so that therapy can continue. We recognize that situations such as job changes or change in family situations can occur. If you need to discuss your personal financial situation related to your child's therapy, please do not hesitate to schedule an appointment with us.

Please be aware that the signature on this policy statement designates the person who is responsible for payment. Other parties can be billed, such as grandparents, or former spouses, but ultimately the party that initiates therapy and signs this form is responsible for ensuring payment. Therapy will be discontinued if payment is not made. Furthermore, payment must be made in advance if someone other than the person bringing the child to therapy is responsible for the bill.

_____(Initial)

INSURANCE

SpeechPath Outpatient Clinic is credentialed with Blue Cross/Blue Shield of Tennessee, Aetna, and United. We will be happy to file a claim through these insurance companies, or to assist you with the information necessary to file a claim with another insurance provider. Regardless of your insurance status, you as patient or guardian acknowledge that you bear the final responsibility for payment for services rendered.

_____ (Initial))

INSURANCE DENIAL

You, as patient or guardian bear the overall responsibility for the payment of your account. If you receive notification from your insurance company or from SpeechPath Outpatient Clinic that a claim has been denied, and you believe the denial to be unjustified, it is your responsibility to a) contact your insurance carrier to discuss the claim, and b) inform SpeechPath Outpatient Clinic of the status of your actions. SpeechPath Outpatient Clinic will not simply resubmit a denied claim without proactive action on the part of the patient or guardian. Should a claim be denied, SpeechPath Outpatient Clinic may reduce the amount due, at our discretion.

_____ (Initial)

COLLECTION ACCOUNTS

SpeechPath Outpatient Clinic will attempt to work with a parent or guardian whose account becomes delinquent. In rare cases, accounts may become severely past due, with no evidence that payment arrangements are being made. SpeechPath Outpatient Clinic employs outside collection agencies.. If an account becomes **over 60 days delinquent**, SpeechPath Outpatient Clinic may refer the account for collection activity. **Upon referral, a 30% collection fee will be added to the outstanding balance of the account.**

_____ (Initial)

CANCELLATIONS

Canceled sessions will not be billed if we receive notice 24 hours prior to the scheduled appointment. If an unexpected emergency or illness occurs, please notify us as soon as possible. Also, we ask that if your child is sick, he/she be fever free for 24 hours before an appointment. The therapist is asked to use their discretion as to whether or not your child is well enough to participate in therapy. We will work with you in an attempt to schedule makeup sessions for illness and other emergencies. **If you are absent from a scheduled sessions without notifying us, you will be charged a $50.00 unexcused absence cancellation fee.** This fee will be the sole responsibility of the guardian, and will not be billed to insurance or third party payer. Therapy services are a high demand industry with significant waiting periods for services. Because of this if 3 sessions are unexcused absences in a 30 day period, SpeechPath retains the right to take the client off of the schedule and the time slot will be given to the next patient on the waiting list. This does not apply if the missed appointment without notice is due to an extreme emergency or planned and approved missed visits.

_____ (Initial)

ATTENDANCE/TARDINESS

Regular and consistent attendance for therapy is important and will impact the amount of progress made. Sessions begin at the scheduled time regardless of whether or not you are on time. Fees can not be adjusted based on tardiness. We want you and your child to receive full benefit from the therapy session, which requires consistent and timely appointments.

_____ (Initial and date)

INCLEMENT WEATHER

Our office schedule does not coincide with private or public school openings or closings due to weather. We will call to cancel sessions if the office is closed. Please call our office or the therapists directly if you are unable to attend your scheduled session due to hazardous driving conditions. Because weather is unpredictable, we understand that advance notice is not always possible. Keep in mind that often times schools are closed while the roads near the office are quite clear, but never jeopardize your safety due to poor driving conditions, just give us a call! _____ (Initial and date)

PARENT INVOLVEMENT

Although tremendous progress can be directly related to therapy, it is extremely important for parents to have direct communication with the therapist so that techniques can be carried on outside of the clinical session. If you wish to leave the office during your child's session, it is imperative that you return before your child's session ends. The

last several minutes of each session are reserved for feedback and suggestions from the therapist. Sometimes homework assignments are given. The parent is expected to assist the child with the assignment or make certain that it is completed independently if the child is older. Homework notebooks are expected to be brought back to each session if assigned by the therapist. If your child sees more than one therapist, please make every effort to see each therapist during the last few minutes of each session.

_____ (Initial)

WAITING ROOM

Please accompany your child into the office and sign him/her in at the front desk. If you wish to run an errand or if another person will be picking your child up, please inform the therapist/office manager and be prompt in your pick-up. Also, please assist us in keeping the noise level to a minimum so that all of our clients will have the opportunity to learn without distractions. A play area for the little ones is available, as well as the waiting area for parents and older children. We request that no food or drinks be consumed in the clinic.

_____ (Initial)

We believe in effective communication! Please do not hesitate to question or comment, we all learn from one another. Your signature below affirms that you have received a copy of the policy and procedures and concur with them.

_____ Signature

_____ Date

CONSENT FOR ASSESSMENT AND TREATMENT

I give SpeechPath Outpatient Clinic my consent to complete a formal evaluation and treatment as indicated. I understand that the results for the evaluation will be explained to me. I also understand that the information obtained from this evaluation is confidential and will only be shared with other specialists with my consent. By signing below I give my consent for evaluation and treatment as indicated. I acknowledge that a copy of this signed authorization shall be as valid as the original.

_____ _____

Parent/ Guardian Signature Date REV 2/19