Children's
Speech & Language Services

KAISER PAYMENT POLICY STATEMENT

All clients are required to keep a current credit card on file with our office.

Children's Speech and Language Services of Springfield, LLC. Is an in-network provider for Kaiser patients. However, a doctor must provide a referral for speech and language therapy. We must have a current authorization on file to render services.

_____ **I understand that I will have a co-payment for services. CSLS-S is not provided any information about co-payment amounts, and they vary from $10 to $50 per session. It is your responsibility to contact Kaiser and find out what your co-payment is. (All must initial)**

_____ **I understand that some Kaiser policies have deductibles. In some cases, families will need to pay for services out of pocket until their deductible is met. (All must initial)**

_____ **I understand that I must pay my co-payment for services at the time that they are rendered. (All must initial)**

_____ **I understand that it is my responsibility to know what Kaiser will cover and to abide by its rules regarding services in our office as well as referrals, pre-authorizations, etc. If you have questions about what Kaiser will and will not cover, you should contact them directly. (All must initial)**

_____ **I would like to pay my co-payment for services using automatic credit card processing at the time services are rendered. I would like this credit card to be used for my co-payments and understand that it will be kept secure. I also understand that it is my responsibility to notify the billing office about the following: 1.) When/if my credit card expires. 2.) When/if my credit card has been compromised. 3.) When/if I would like to use a different credit card or form of payment.**

CREDIT CARD INFORMATION.
Name of Client: _____
Name on the card: _____
Credit Card Number: _____ Expiration Date _____
CSC (3-digit code on the back of the card) ____ _____ _____

Cardholder's signature: _____

If co-payments are 20 days past due, CSLS-S will assess a late fee in the amount of $50.00. If a personal check is returned because of insufficient funds, CSLS-S will assess a fee of $35.00. <u>If a co-payment balance is past due for more than 45 days, therapy will be suspended and your child's weekly therapy time slot will be released to someone on our waiting list.</u>

I authorize CSLS-S to apply for benefits for covered services on my behalf. I request payment to made directly to CSLS-S. I certify that the information I have provided regarding my insurance coverage is correct.

<u>PRIMARY INSURANCE HOLDER MUST SIGN.</u>

_____ _____ _____

Date Signature / Printed Name