TRICARE 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 out of network participating provider with Tricare. That means that CSLS-S, although we will file your claim for you *as a courtesy,* we do not accept assignment. Please Initial the following statements:

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

_____ **I understand that because CSLS-S is an out of network participating provider, Tricare will send reimbursement for claims directly to me. (All must initial)**

_____ **I understand that if I am retired, I will have a co-payment for services. This will be stated on your Explanation of Benefits that you receive from Tricare. (All must initial)**

_____ **I understand that it is my responsibility to know what Tricare 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 Tricare will and will not cover, you should contact them directly. (All must initial)**

_____ **I understand that a doctor's prescription for speech and langue therapy must remain up to date and filed with Tricare in order for us to successfully file your claim. It is my responsibility to keep this prescription updated.**

_____ **I would like to pay for services using automatic credit card processing at the time services are rendered. I would like this credit card to be used for payment 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 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 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 have read the above Payment Policy Statements and my signature below is confirmation that I understand I am ultimately responsible for full payment of services provided by the professionals at CSLS-S. I understand that Children's Speech and Language Services of Springfield does not guarantee that any portion of the services provided by its professionals, will be automatically covered by my insurance carrier.
<u>PRIMARY INSURANCE HOLDER MUST SIGN.</u>

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Date Signature / Printed Name

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