Children's
Speech & Language Services

2017 INSURANCE PAYMENT POLICY STATEMENT rev 07/17

All clients are required to keep a current credit card and e-mail address on file with our office.

I choose to have Children's Speech and Language Services, Inc. (CSLS) to file my insurance claims and agree to provide all the pertinent documentation, (i.e.: a signed HCFA 1500 Form; a completed and signed Payment Policy Statement; a copy of your insurance card (front and back); and the written referral from your physician).

Please initial the following. Choosing automatic credit card processing is the only optional choice:

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

_____ **I understand that if CSLS receives payment from my insurance company, the payment will be credited to my account and reflected in my payment balance. (All must initial)**

_____ **I understand that I am obligated to cover all costs or fees that my insurance denies. (All must initial)**

_____ **I understand that it is my responsibility to pay for my child to participate in a social skills group (CPT code 92508) at a rate of $100 per session. I, as a patient, have the right to bill the service to my insurance for reimbursement.**

_____ **I understand that I will receive all future invoices via email. (All must initial).**

Email address: _____ Child's Name: _____

_____ **I choose 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 new credit card/form of payment.

_____ **I choose to pay for my services by check.**

CSLS will file weekly insurance claims on the universal HCFA 1500 Form. This information must be provided in full for our office to process claims.

Insurance Co. Name: _____
Identification Number: _____

Insurance Co. Address _____
(claims to be mailed) _____
Referring Physician Name: _____
Physician's Address: _____
_____

Credit Card Information
Name on Card: _____
Credit Card Number:
_____

Expiration Date _____
CSC (3 digit code): ___ ____ _____
Zip Code _____

If payments are 20 days past due CSLS will assess a late fee in the amount of $50.00. If a personal check is returned because of insufficient funds, CSLS will assess a fee of $35.00. 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.

I have read the above Payment Policy Statement and my signature below is confirmation that I understand I am ultimately responsible for full payment of services provided by the professionals at CSLS. I understand that Children's Speech and Language Services does not guarantee that any portion of the services provided by its professionals, will be automatically covered by my insurance carrier. PRIMARY INSURANCE HOLDER MUST SIGN.

_____ _____ / _____
Date Signature Printed Name

_____ _____ / _____
Date Signature Printed Name