Children's
Speech & Language Services

KAISER PAYMENT POLICY STATEMENT Revised 7-2017

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

Children's Speech and Language Services, Inc. (CSLS) 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 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 will receive all future invoices via email. (All must initial).**

Email address: _____ Child's Name: _____

Additional email address: _____

_____ **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 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 Kaiser for reimbursement.**

_____ **I understand that I must pay my co-payment for services weekly. I agree to pay my co-payment for services using automatic credit card processing weekly.** 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.

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) ____ _____ _____ Zip Code: _____

Cardholder's signature: _____

If co-payments are not kept current, following two unpaid co-pays, therapy will be suspended and your child's weekly therapy time slot will be released to someone on our waiting list. If credit card payment is declined twice, services will be suspended indefinitely.

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

_____ _____
Date Signature / Printed Name

_____ _____
Date Signature / Printed Name