Children's
Speech & Language Services

CIGNA PAYMENT POLICY STATEMENT Revised 7-2017

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

Children's Speech & Language Services, Inc. (CSLS, Inc.) is an in-network provider for CIGNA 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/or coinsurance for services. CSLS, Inc. is not provided any written information about co-payment amounts, and they vary from $10 to $50 per session. It is my responsibility to contact CIGNA and find out what my co-payment is. I also understand that some CIGNA policies have deductibles and I need to find out my family's deductible. In some cases, families will need to pay for services out of pocket until their deductible is met. (All must initial)**

_____ **Should CIGNA request my child's records from CSLS, Inc., per our contract, CSLS, Inc. is required to release any reports, including outside reports from doctors/schools etc. I agree to such release of records.**

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

Email address: _____ Child's Name: _____

_____ **I understand that it is my responsibility to know what CIGNA will cover and to abide by its rules regarding services in our office as well as referrals, pre-authorizations, etc. If I have questions about what CIGNA will and will not cover, I must 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 CIGNA for reimbursement.**

_____ **I understand that I must pay my co-payment/ or coinsurance for services weekly. I understand that I must pay my co-payment/ or coinsurance 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: _____ Zip Code: _____
Name on the card: _____ Expiration Date: _____
Credit Card Number: _____ CSC (3-digit code): ____ _____ _____

Cardholder's signature: _____

If co-payments/co-insurance are not kept current, following two unpaid weeks of service, 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, Inc. to apply for benefits for covered services on my behalf. I request payment to made directly to CSLS, Inc. 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