SELF-PAY POLICY STATEMENT

Rev 7/17

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

_____ **I understand that Children's Speech and Language Services, Inc. (CSLS, Inc.) files insurance claims as a courtesy to families. However, I choose to pay out-of-pocket for my child's speech and language therapy services.**

_____ I agree to pay for services at the time they are rendered and understand that an invoice with necessary information (FEIN, CPT and ICD.10.CM diagnostic codes) will be provided for each Date of Service.

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

Email address: _____

_____ **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.**

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: _____

_____I understand that failure to pay for services at the time of each visit could result in late fees.

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. <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>

Both parents/guardians listed on the client's case history form must sign below.

I have read the above Self-Pay 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 Children's Speech and Language Services, Inc.. CSLS, Inc. does not guarantee that all services provided by its professionals will be automatically covered by your insurance carrier. I understand that Children's Speech and Language Services, Inc. contract is with me, the client, not my insurance carrier.

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Date Signature Printed Name

_____

Date Signature Printed Name