Children's
Speech & Language Services

2017 INSURANCE PAYMENT POLICY STATEMENT rev 01/17

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

I would like Children's Speech and Language Services of Springfield 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-S 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 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.

CSLS-S. 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): ___ ____ _____

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 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-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>

_____ _____ _____

Date Signature / Printed Name

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