



Speech & Language Stimulation Center, Inc.

317 North Meldrum
Fort Collins, CO 80521
(970) 495-1150

Client Rights, Office Policies, Financial Agreement

Your Rights

Consent for Treatment: You hereby consent to such treatment procedures and client care which, in the judgment of your therapist and/or physician, may be considered necessary or advisable while a client of the Speech & Language Stimulation Center, Inc. (SLSC).

Patient Rights:

You have the right to see your own (or your child's) health information

1. You have the right to request changes to your own (or your child's) health care record
2. You have the right to choose how we send the medical records to you
3. You have the right to request your own (or you child's) copies of confidential communications
4. You have the right to file complaints with the Department of Health & Human Services' Office of Civil Rights

Release of Information: You authorize release of information to the referring doctor/agency. You further authorize SLSC to use or release any records that it may have concerning you to individuals acting in official capacities as your advocate representing government, third party payors, governmental agencies, regulatory or review agencies. You understand that this authorization may be revoked in writing by you at any time and that any such revocation will be effective as of the date such written revocation is received by SLSC.

Rights and Responsibilities: You have been given a copy of SLSC's Notice of Privacy Practices and Financial Agreement and have had the opportunity to ask any questions that you may have about them.

Please read and initial

Office Policies

- _____ 1. Scheduled appointment lengths include the following (unless otherwise stated to you):
30 minutes = 25 minute contact time and any discussion about home program + 5 minutes to use on you/your child's behalf for preparation, analysis of treatment activities, planning for the next session and charting
45 minutes = 40 minute contact time and any discussion about home program + 5 minutes to use on you/your child's behalf for preparation, analysis of treatment activities, planning for the next session and charting
60 minutes = 50-55 minute contact time and any discussion about home program + 5-10 minutes to use on you/your child's behalf for preparation, analysis of treatment activities, and charting
- _____ 2. When you schedule an appointment, you have "purchased" the therapist's time. No one else can then contract for that time. Therefore, **appointments that are cancelled or rescheduled with LESS than 24-hour notice will be charged a Late Cancellation fee of \$50.00. Appointments that are "No Show," meaning the client did not come for a scheduled appointment and did not call in advance to cancel, will be charged a No Show fee of \$75.00.** Chronic late cancellations or no-shows (max of 3) will result in you losing your preferred standing appointment time.
- _____ 3. Coming late for an appointment means a shorter appointment for the client (still at the scheduled charge).
- _____ 4. The clinic will make every effort to obtain benefit information for you from your insurance. This information is obtained in a good-faith effort, and is **not** a guarantee of payment by your insurance company. If your insurance company does not pay for the billed charges, the charges are patient responsibility. Sometimes we are informed that insurance will pay, but they reserve the right to deny claims.

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Please read and initial

- _____ 5. Payment for treatment is expected at the time of service
- _____ 6. Each therapy session outside the office has an additional \$7.50 trip fee

Continuity of Care

_____ Our therapists work closely with each other so if your therapist is out of the office (vacation or sick time) you/your child will have another therapist in this office to see so that you/your child's therapy may continue without interruption.

Financial Agreement

_____ **Statement of Financial Policy:** As noted above, if SLSC is contracted with your insurance company, we will file your insurance claims for you and agree to accept your insurance company's fee schedule when processing their payment. You understand that the following conditions apply:

1. You understand that you are ultimately responsible for any portion of your bill that your insurance company does not pay.
2. Payment is expected within thirty (30) days from receipt of billing.
3. You understand that regardless of the type of insurance coverage you may have, policies are a contract between yourself and the insurance carrier. Furthermore, you are ultimately responsible for payment.
4. You accept responsibility for providing us with a current, valid insurance card for the purpose of identification and verification of your insurance coverage. If your claim is denied because of lack of coverage or because your insurance company does not pay for the service rendered, you will be responsible for the entire balance on your account.
5. You will be responsible for any collection cost, including reasonable attorney fees.

Authorization for Payment/Assignment of Benefits: You authorize SLSC to bill for services and receive payment from the payer source confirmed with you at the time of admission. You hereby request and authorize payment directly to SLSC of any Medicaid, insurance, or third party benefits otherwise payable to you for services. Co-pays and any supplies that insurance does not cover are the responsibility of the patient and are due at the time of visit or it will be billed directly to the patient. You understand that it is your responsibility to notify SLSC of any and all changes in payer sources for these services. You certify that the information given by you in applying for payment under Title XVIII or XIX of the Social Security Act is correct. You understand that you are financially responsible to SLSC for charges not covered by this assignment and consistent with state and federal law. The SLSC may release any information concerning you that SLSC may obtain in order to support any request for payment for SLSC. **A 1.5% monthly finance charge, not to exceed 18% annually, is added to patient balances over 120 days.**

_____ **Patient Name**

_____ **Date of Birth**

_____ **Signature of Responsible Party**

_____ **Date Signed**

_____ **Front Office Representative**

_____ **Date Signed**