

# BEYOND THERAPY

CORRECTIVE SPEECH AND LANGUAGE THERAPY, INC.

4219 Flora Vista Drive, Orlando, FL 32837 (407) 857-6285 fax (407) 857-9566

www.centrafltherapy.com

## Policies and Agreements

Patient's name: \_\_\_\_\_

### Change in Coverage Policy

Beyond Therapy will bill your insurance, Medicaid, or Part C for Therapy services rendered. However, if you or your child has any change in coverage, including:

- ❖ Change in Medicaid provider
- ❖ Loss of Medicaid coverage
- ❖ New private insurance policy
- ❖ Change in private insurance policy
- ❖ Loss of Private insurance
- ❖ Any other change in your child's insurance coverage

You **MUST** contact our office immediately (407-857-6285). We must be informed or it may be impossible for us to bill your insurance or Medicaid carrier. \*\*\*\*\***You will be billed for any charges that cannot be paid because of changes to you or your child's coverage and/or any denied claims.**

### Missed Visit Policy

**There will be a \$25.00 charge to you for all missed appointments that are not canceled at least 24 hours** prior to the scheduled appointment time. Your insurance company will not pay for missed visits, and you will be responsible for paying out of pocket. If your therapist has not provided you with a phone number, call 407-857-6285 to cancel your appointment.

**3 consecutive missed visits** will result in your therapy being placed on hold. It will be necessary to contact the main office for re-scheduling. Please limit your missed visits! **After 3 missed visits in any one month**, your therapist reserves the right to place your child on hold for services. Please be courteous to your therapist and make sure you give ample notice when canceling.

### Insurance Payment Policy/Agreement

As a courtesy to our patients, Beyond Therapy will file therapy service claims with your primary medical insurance company. However, our office policy is to expect full reimbursement from the patient or guardian within 15 days after receipt of the invoice. Payments that are collected from the insurance carrier will be reimbursed in full to the policyholder, or applied as a credit to the policyholder's account.

I agree to pay in full for services provided by Beyond Therapy (Corrective Speech and Language Therapy, Inc.) within 15 days of receipt of invoice and understand that any payments collected from my insurance company will be reimbursed to me in full. **I understand that I will be responsible for paying for any services that my insurance company denies.** Note: Patients with Medicaid or Part C coverage will not be billed upfront for services.

By signing this document, you are stating that you have read, understand and agree to the terms listed above.

To be signed by the patient or primary guardian of patient:

Please print name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_