



CORRECTIVE SPEECH AND LANGUAGE THERAPY, INC.

4219 Flora Vista Drive, Orlando, FL 32837

Ph: 407-857-9566 fax: 407-857-9566

www.centralfltherapy.com

CREDIT CARD INFORMATION FOR FILE

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 after the fact, will be reimbursed in full to the policyholder, or applied as a credit to the policyholder's account.

_____ I understand that my credit card information will be kept on file and I will be notified prior to any charges made to my card.

_____ 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 Early Steps coverage will not be billed upfront for services.*

_____ I understand that my credit card on file will be charged if payment is not received within 15 days after the invoice date.

_____ I authorize Beyond Therapy to charge the balance of my account to my credit card if alternative means of payment are not met by the 15 day deadline.

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:

Patient's name: _____ Please print name: _____

Relationship to patient: _____

Signature: _____ Date: _____

Credit Card Info:

M/C VISA CARD # _____ Expiration Date: _____

Security Code: _____ Name as it appears on card: _____