BEYOND THERAPY
CORRECTIVE SPEECH AND LANGUAGE THERAPY, INC.
14055 Town Loop Blvd. Suite 300, Orlando, FL 32837
(407) 857-6285 ph. (407) 857-9566 fx.
www.centralfltherapy.com

Office/Financial Policy Agreement

(Please read carefully)

Thank you for choosing Beyond Therapy for your therapy treatment. We are committed to providing you with quality, individualized treatment to achieve optimal progress. We appreciate your commitment to adhere to our office **Office/Financial Policy Agreement**. By understanding and agreeing to our policy, we can provide you with the highest standard of treatment. Therefore, it is our policy to make financial arrangements before the treatment is started.

Except as indicated below, ***Payment is required at the time services are rendered*** unless other arrangements have been made in advance. We accept cash, in-state checks, VISA, and MasterCard. There is a **$40.00** service charge for returned checks. _____

OFFICE HOURS:

Monday and Friday: 8:30am-5pm Tuesday, Wednesday, Thursday: 8:30am-7pm Saturday: 9am-1pm (certain therapists only)

CANCELLATIONS/ RESCHEDULING:

It is our policy to receive at least **24 hours notice** for all appointment changes or cancellations. Failure to provide our office with adequate notice will result in a **$25.00** charge to your account. 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 or email Gabby@centralfltherapy.com to change or cancel your appointment. As a courtesy, we try to confirm future appointments with you at check out. _____

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 cancelling. _____

Please be courteous to our other patients and be on time for your appointment. If you are more than 15 minutes late, your therapy session will be reduced or you may need to reschedule. _____

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS:

I authorize Beyond Therapy dba/Corrective Speech and Language Therapy, Inc. to release any of my medical information to my insurance company(s), as needed to process my insurance claim. I authorize my insurance company to make payment directly to Beyond Therapy dba/Corrective Speech and Language Therapy, Inc. for covered therapy services.

_____ _____

Patient's name Responsible Party's signature (parent/guardian of minor)

_____ _____

Date Printed name

_____

Relationship to Patient

Continued on the next page

Office/Financial Policy Agreement Continued

INSURANCE:

For our patients with Health Insurance that we accept: Your health insurance is an agreement between you and your insurance company. We make every effort to help you understand your therapy benefits using the insurance information you provide. We will call your insurance company and receive a breakdown of benefits for therapy. The information we receive from your insurance company will allow us to provide you a rough estimate. We can only ESTIMATE your benefits as provided by your insurance company.

It is still YOUR responsibility to know your insurance benefits including eligibility, covered benefits, medically necessary procedures and **exclusions**. Please contact the customer service at your insurance company to discuss benefits for therapy services prior to your appointment. **You are responsible for any charges not covered by your plan regardless of the reason for denial**. As a courtesy to you, we will gladly bill your insurance company, but your estimated portion is due at the time of service**.** _____

Once our office receives an explanation of benefits from your insurance company, we will send you an invoice for any portion that is unpaid. Our office policy is to expect full reimbursement from the patient or guardian within 7 days after receipt of the invoice. Any payments collected from the policy holder that results in an over payment will be reimbursed in full to the policyholder, or applied as a credit to the policyholder's account. _____

OUT-OF-NETWORK: If we do not participate with your insurance carrier, payment in full is required at the time of service. If you have out-of-network benefits, we will gladly bill this insurance as a courtesy to you. The out-of pocket expenses will be greater if you choose to use this option.

UNINSURED/SELF PAY: payment in full is due at the time of service. We accept credit cards (Visa and Master card), checks, and cash. Beyond Therapy strives to help every patient and therefore, we will be able to offer a discount to self-pay patients. If you have any questions, please ask us for more information.

In the event an account is turned over for collection, the responsible person for the account agrees to pay all collection and/or attorney's fees, court costs, and other reasonable costs of collection. Accounts over 60 days may be charged 18% per annum interest on unpaid balance. _____

CHANGE IN COVERAGE

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/insurance policy, Loss of Medicaid/insurance coverage, change in insurance policy, New private insurance policy, or 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.**

I agree to pay in full for services provided by Beyond Therapy (Corrective Speech and Language Therapy, Inc.) at the time of the appointment. If Beyond Therapy files a claim for my insurance company for me, I agree to pay for non-covered insurance benefits, co-insurance, copays and deductibles. Any invoices received from Beyond Therapy for unpaid dues will be paid within 7 days of receipt of invoice. **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 all of the terms listed in our office and financial agreement.

_____ _____

Patient's name Responsible Party's signature (parent/guardian of minor)

_____ _____

Date Printed name

_____

Relationship to patient