

EXPLANATION OF PATIENT FINANCIAL RESPONSIBILITY

In order to maintain our fee at the lowest possible, level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to read this carefully, discuss it with us, and ask questions.

- ❖ We will bill your insurance company for you if you desire; however, you must pay the full amount at the time of the service.
- ❖ If by mistake, your health plan remits payment to us we will either refund it to you or credit your account, whichever you prefer.
- ❖ Your health plan may refuse payment of the claim for some of the following reasons:
 1. This is a pre-existing illness which is not covered by your plan.
 2. You have not met your full calendar year deductible.
 3. The type of medical service is not covered by your plan.
 4. You have other insurance that must be filed first.

Please understand that financial responsibility for medical services rests between you and your insurance company. While we are pleased to be of service by filing your medical insurance for you if you are a member of a PPO or HMO, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies a claim for any of these reasons, our office cannot be responsible for the bill. It is your responsibility as a patient to know exclusions and regulations of your plan.

Our primary mission is to provide you with quality, cost effective care. Together, we are trying to adapt to the changing way health care is financed and delivered. We value you as a patient and our first priority is to provide you with the best possible care. With this housekeeping chore complete, we are pleased to serve you.

I have read and understand my obligations and acknowledge that I am fully responsible for payment of any services not covered by my insurance carrier.

Signature of Patient/Guardian

Patient Name Printed

I have read and agree to the policies of Speech Enterprises, Inc. including the notification of cancellation policy (#5). I understand that I or my child is subject to dismissal from therapy if the policy statement guidelines are not followed.

Signature of Patient/Guardian

Patient Name Printed