SPS

Speech Pathology Services

FEES, CANCELLATIONS, AND INSURANCE

The following information details the cost, cancellation and insurance policy. Please keep this information in your file. These policies were made to establish a procedure to keep costs reduced, and to best maximize therapy time.

I. Fees

A.	Speech/Language Evaluation	$300.00
B.	Voice Evaluation	$150.00
C.	Therapy	$90.00 (per ¾-1 hour)
		$55.00 (per half hour)
D.	Late Cancellation	$20.00

II. Cancellation

A. 24 hour notice of cancellation is required.

B. You will be charged for that time if we do not have proper notification. Previous abuse of cancellation has made it necessary to adhere to this policy.

III. Insurance

A. If your policy requires referral/pre-authorization, it is your responsibility to obtain the initial authorization **before** the visit. If we have referral/authorization, we accept payment by the insurance company except for your co-payment.

B. If we are not providers for your insurance company, it is your responsibility to collect from your insurance company. Fees are payable at each visit, unless otherwise arranged.

C. If the insurance company does not provide payment you will be responsible for the full amount.

D. To insure payment to Speech Pathology Services, please sign the following statements so that we have your signature on file.

Please sign below to indicate your understanding of the above policies.

Thank you for your cooperation. Please remember that you will be billed for appointment time that is not cancelled with 24 hour notice.

______________________________, __________________

Patient's Signature Date

______________________________, __________________

Clinician's Signature Date

12700 Hillcrest Road, Suite 276, Dallas, Texas 75230

SPS

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NOTICE OF INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ CAREFULLY AND THEN SIGN BELOW:

- If you are involved in a third party litigation, any law firm involved in the case may request copies of any an all chart notes, reports and billing statements within our possession. We must receive a signed consent from you to release this information.
- Your insurance company may request copies of any and all chart notes, reports and billing statements within our possession.
- We may send your referring Doctor, Primary Care Physician, Nurse Case Manager any and all initial evaluations, progress notes, and discharge summaries so that they are kept appraised of your progress and to authorize continued speech therapy.
- We may use your personal information to obtain a referral authorization from your Primary Care Physician or Specialist so that your insurance company will cover the cost of your treatment.
- We may release your personal information to our contracted billing service, **ENS an INGENIX Company**, so that they may assist us in billing your insurance company for the services provided by this office.
- We may use your information to verify benefits, co-payment amounts and billing information with your insurance company.
- You are entitled to a copy of any and all chart notes, reports and billing statements within our possession and may request them at any time. We must have a signed release from you signed within the previous 30 days to release this information.
- You are entitled to request any and all names of companies and individuals that have requested your information from this office.

By signing below, I acknowledge that I have read and understand how my Personal Health Information may be used and disclosed by Speech Pathology Services.

Signature: ________________________________ Date: ____________________

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Speech Pathology Services

RELEASE OF INFORMATION

Please sign the following releases so we may obtain and/or release necessary records.

1. I understand that Speech Pathology Services is in compliance with the federal privacy protection regulations and I agree to the release of any requested information to Speech Pathology Services.

   ______________________ ______________________
   Signature Date

2. I authorize Speech Pathology Services to release information to the physicians or other specialized personnel who may request it.

   ______________________ ______________________
   Signature Date

3. I agree to permit the use of tape recordings and videotape for patient information and teaching purposes only.

   ______________________ ______________________
   Signature Date

4. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

PATIENT RESPONSIBILITY

I understand that I am financially responsible to SPS for services where insurance authorization has lapsed or been denied. SPS will not accept assignment of insurance for such services unless an authorization is required and obtained.

By signing below, you are acknowledging that you understand the above statement and agree to be personally and fully responsible for payment should insurance carrier deny payment.

______________________ ______________________
Signature **Date**