



CREATIVE SPEECH SOLUTIONS, LLC

Pediatric Therapy Center

PATIENT LIABILITY STATEMENT

We **will not** initiate therapeutic services until signed authorization is provided.

I understand that I am personally responsible for charges incurred for services rendered by the office of Creative Speech Solutions, LLC if any of the following apply:

1. My health plan does not cover 100% of the services rendered for any reason.
2. I do not provide the office of Creative Speech Solutions, LLC with the correct insurance information.
3. I have chosen not to use my medical coverage at the time services are rendered.
4. I have a medical plan with a carrier that would be considered by this office to be "out of network."
5. I have not obtained the proper referral or authorization for the services provided.
6. My benefit parameters limit or exclude coverage for therapy services.
7. My coverage changes during the course of therapy.
8. I exceed my benefit limitations.

I understand that claims not paid after 90-days by in-network providers automatically become the responsibility of the guarantor/subscriber.

I understand that if I must appeal my insurance company's decision regarding coverage, I will pay for services (past and present) until the appeal process is complete.

I understand that Creative Speech Solutions, LLC is not in-network with any insurance carriers for Occupational Therapy, Nutritional Services, or Music Therapy.

I understand that outstanding balances that are not paid within 60 days will be charged to the credit card I have on file with Creative Speech Solutions, LLC.

I have read and understand the welcome letter summarizing policy and procedures set forth by Creative Speech Solutions, LLC. By signing below, I hereby agree to the terms and conditions and authorize Creative Speech Solutions, LLC to provide services to my child.

Print Patient's Name _____

Signature of Responsible Person(s) _____

Date _____



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CREDIT CARD AUTHORIZATION FORM

I authorize Creative Speech Solutions, LLC to charge my Credit Card from
_____ (Visa or MC).

Credit Card Number _____ Expiration Date: _____
CVV# _____

Credit Card Billing Address: _____

City _____ State _____ Zip Code _____

I acknowledge and understand that the above-referenced is for services rendered on my behalf and at my request by Creative Speech Solutions, LLC. I acknowledge that, by providing this service Creative Speech Solutions, LLC has met its obligations for these charges. In the event that I am more than 60 days overdue in paying my outstanding bill, I give Creative Speech Solutions, LLC consent to charge this credit card. I acknowledge that this agreement may be cancelled with written notice at any time.

I am enclosing copies of my credit card front and back. I agree to provide updated credit card information if this card should expire or be cancelled.

Signature of Cardholder: _____

Date: _____



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PATIENT INFORMATION SHEET

DATE: _____
CHILD'S NAME: _____ D.O.B: _____ AGE: _____
PARENTS/GUARDIANS: _____
STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
HOME#: _____ MOBILE#: _____ OFFICE#: _____
EMAIL 1: _____ EMAIL 2: _____
PEDIATRICIAN: _____
STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
OFFICE#: _____ FAX#: _____

INSURANCE INFORMATION

INSURANCE CO: _____ ID#: _____ GROUP#: _____
STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____
POLICY HOLDER'S NAME: _____ POLICY HOLDER'S DOB: _____
INSURANCE TYPE: (CHECK ONE)
HMO: _____ POS: _____ PPO: _____ BOE: _____ (IF BOE COMPLETE BELOW)
BOARD OF EDUCATION/SCHOOL DISTRICT: _____
STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE#: _____

OTHER PERTINENT PHYSICIANS OR THERAPISTS (E.G., NEUROLOGIST, ENT, OT, PT, SLP, ORTHOPEDIST)



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Patient: _____

CONSENT FOR TREATMENT

I hereby authorize Creative Speech Solutions, LLC, to assess and treat the above-named client using appropriate assessment and treatment procedures.

AUTHORIZATION TO RELEASE INFORMATION

I further authorize Creative Speech Solutions, LLC, to release information acquired in the course of evaluation and/or treatment to appropriate individuals/insurance companies/facilities/schools in order to coordinate services or receive reimbursement. This would include treatment reports, progress notes, and general discussion of the child (e.g., behavioral management, therapy goals, etc.). Individuals would include the child's pediatrician, other physicians (e.g. neurologist), other treating therapists (e.g., school SLP, occupational therapist, etc.), and other specialists (e.g., psychologist). If there are any individuals and/or facilities to whom you do not wish information to be released, please list them below:

PAYMENT GUARANTEE

I have read the "Welcome" Letter, which outlines the office policies and procedures regarding appointments, health insurance and payment guidelines. I do hereby agree to pay to Creative Speech Solutions, LLC the full and entire amount of any and all bills rendered for such services provided for the above-named client.

Responsible Party _____

Relationship _____

Signature _____

Date _____

VIDEOTAPE PERMISSION (optional)

I hereby authorize Creative Speech Solutions, LLC to videotape the above-named client to document and to study therapeutic practices.

Responsible Party _____

Relationship _____

Signature _____

Date _____



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**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I, _____ have received a copy of this office's
Notice of Privacy Practices.

Please Print Name

Signature

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,
but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)
