CREATIVE SPEECH SOLUTIONS, LLC

Pediatric Therapy Center

PATIENT LIABILITY STATEMENT

(Updated 6/17)

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/school district 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 health plan that considers this office to be out of network or not otherwise a covered provider of service.
5. I have not obtained a referral, preauthorization or other required authorization.
6. My benefit parameters limit or exclude coverage for therapy services.
7. My coverage changes during the course of therapy and/or no longer or does not cover and/or limits and/or excludes my therapy services.
8. I exceed my benefit limitations.

I understand and agree that in network or out of network claims not paid by my insurer/school district after 90-days become the responsibility of the guarantor/subscriber.

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

I understand and agree that if Creative Speech Solutions, LLC submits my claim(s) for services as an in-network provider, bills for services rendered but not allowed, covered or reimbursed to Creative Speech Solutions, LLC by my insurer are due upon receipt of said bill. All other bills for services rendered are also due upon receipt, including but not limited to bills for co-pays, deductible amounts and therapy. I also understand and agree to pay interest at a yearly rate of 12% on any remaining balance not paid within 30 days from the date of any bill. I understand and agree to pay any collection fees or costs, attorney's fees, and/or related costs and expenses incurred in pursuing any balance not paid within 90 days from the date of the bill.

I understand and agree that all outstanding balances that I have not paid within 30 days will be charged to the credit card I have on file with Creative Speech Solutions, LLC.

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

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

☐ I would like to receive my monthly billing statements via email.

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_____

☐ **Please charge the above credit card on a monthly basis for services and/or copayments. I understand that a receipt will be emailed to me once the card is charged and payments have been applied to my account.**

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.

Patient's Name:_____

Name of Cardholder:_____

Signature of Cardholder:_____

Date:_____

CREATIVE SPEECH SOLUTIONS, LLC

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PATIENT INFORMATION SHEET

DATE:_____

CHILD'S NAME:_____ D.O.B:_____ AGE:_____

PARENTS/GUARDIANS:_____

ADDRESS: _____

CITY:_____ STATE:_____ ZIP: _____

ALTERNATE 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:_____

POLICY HOLDER'S SOCIAL SECURITY NUMBER_____

PLEASE NOTE THAT CSS IS IN NETWORK WITH CIGNA AND AETNA FOR SPEECH THERAPY.
ALL OCCUPATIONAL THERAPY SERVICES ARE OUT OF NETWORK.

BOARD OF EDUCATION/SCHOOL DISTRICT:_____

STREET ADDRESS: _____

CITY:_____ STATE:_____ ZIP: _____

Please list your child's allergies:_____

☐ **My child does not have any allergies that I am aware of.**

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

_____

_____

_____

Signature:_____

CREATIVE SPEECH SOLUTIONS, LLC

Pediatric Therapy Center

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:

_____

_____

_____

_____

CANCELLATION POLICY

I have read the "Welcome" Letter, which outlines the cancellation policy. I understand that:

1. All cancellations made with less than 24 hours' notice, for any reason other than the illness of the treated patient, will be charged a cancellation fee ($50 for 30 minutes, $60 for 45 minutes and $75 for one hour sessions).
2. This fee cannot be billed to my insurance company.

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)

_____

_____

_____

_____