Financial Policy

Rate as of February 15, 2016: $105 per 45-minute session
If you pay a copay: your co-pay will remain the same.
If you private pay: $105 per 45-minute session.
If you private pay at or before time of service: 15% discount (-$16).
Final amount due on date of session becomes $89.
If you pay co-insurance: If your rate was $8.70, it will become $10.50 per session.
If your rate was $17.40, it will become $21.00 per session.

Financial Responsibility and assignment of Insurance Benefits

By signing below, you agree that you have read this document.

1. Private-pay clients: Payments are always due at the time of service.
2. Co-pays: Are always due at the time of service. You may be asked to reschedule the appointment if you are not prepared to make this payment required by your insurance company contract.
3. To make it easier for you to make timely payments, we accept credit cards.
4. If we receive a returned check for non-sufficient funds, the account on which you were making payment will be charged a $25 fee. This fee is due and payable upon receipt.
5. You are responsible for knowing your insurance benefits, including what is not covered. We bill the insurance companies in our network when you provide us with current and complete information. By signing below, you agree that you are responsible for paying for all services denied and for amounts not paid under this assignment, including your health insurance deductible, coinsurance, copays and visits that exceed authorized limits.
6. Even though an insurance claim may be pending, you may receive a statement if your account has an outstanding balance. The Hello Clinic cannot accept responsibility to collect your insurance claim or to negotiate a settlement on a disputed claim.
7. You are responsible for the timely payment of your account.
8. Accounts assigned to a credit reporting and collections service will be charged a $50 collection fee. Should the account be referred to an attorney for collection, the undersigned shall also pay reasonable attorney's fees and collection expense.

I, as the responsible party, hereby authorize payment directly to The Hello Clinic, for speech therapy services. This authorization is effective for all providers for whom The Hello Clinic is authorized to bill in connection with its services. I understand I am financially responsible for all amount not paid under this agreement. I have read, fully understand and agree to the above statements.

Signature of Legal Guardian:_____Date:_____

Print name of signed above:_____

Print name of client:_____

Client's date of birth:_____