SPEECH THERAPY ASSOCIATES

14455 SW Allen Boulevard, Suite 100
Beaverton, OR 97005
Phone: 503-646-0837 FAX: 503-643-5057

Patient Financial Policy

We would like to thank you for choosing Speech Therapy Associates as your health care provider. This is an agreement between Speech Therapy Associates and you, the patient. By signing this agreement, you are agreeing to pay for all services provided to you and on your behalf by Speech Therapy Associates. Please read the following carefully, and ask if you have any questions.

Please initial each section below.

_____ **Payment options if you have insurance:**
Insurance is a contract between you and your medical carrier and we are not a party to this contract. We will file insurance claims as a courtesy to our patients. We cannot negotiate issues related to deductibles, co-payments, covered charges, or eligibility. Co-pays are due at time of service. If we have not received payment from your insurance carrier within 60 days, you will be responsible for services rendered. In the event that we receive payment from your insurance carrier after you have paid, we will return the insurance payment directly to you.

We will estimate what your insurance carrier will pay, however your insurance company makes the final determination of your eligibility and benefits. If your carrier is not contracted with us, you agree to pay any portion of the charges not covered including those above the usual and customary allowance.

_____ **Payment options if you have no insurance:**
Payment is due at time of service. You may pay by cash, check, or credit card. We offer a 10% discount for full payment at time of service. Patient financing is available through partner companies.

_____ **Referrals and Pre-authorizations:**
Your insurance carrier may require a referral from your physician and/or a pre-authorization for us to provide services. It is your responsibility to obtain a referral or preauthorization if required by your insurance company. Please note that failure to obtain a referral and/or pre-authorization may result in a decreased or no payment from your insurance company, and the balance will be your responsibility.

_____ **Returned Checks:**
There is a fee of $20.00 on all returned checks not honored by the bank.

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_____ **Past Due Accounts:**
Accounts 60 days past due will be assessed a 2% finance charge monthly. If your account becomes past due, we will take steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs incurred, including reasonable lawyer fees and court costs as necessary.

_____ **Monthly Statement:**
If you have a balance on your account, we will send you a monthly statement. If additional statements are desired, please contact our billing department.

_____ **Cancellation Policy:**
Consistency in attending services is important for successful progress. Scheduled appointments are held for you and are not available to others. If you are unable to keep an appointment, please call at least **24 hours** in advance to avoid a no-show fee. Missed appointments will be billed at $100.00 and are not covered by insurance. Exceptions include weather-related closures and emergencies.

Thank you for the opportunity to provide your health care services. Your assistance and cooperation is appreciated. By signing below, you acknowledge that you have read and understand the financial policies described above, and have had the opportunity to ask questions.

Patient name: _____

Responsible party : _____ Relationship: _____

_____ **I elect to have Speech Therapy Associates bill a third party (insurance or other) and bill me monthly.**

OR

_____ **I elect to pay at time of service and receive the above discount.**

Signature: _____ Date: _____