92-29 Queens Blvd. Suite 2A Rego Park, NY 11374
Phone: 718 830 0380 Fax: 718 830 0390
e-mail: kmilla@sldq.org
web: www.sldq.org

Speech-Language Development, SLP P.C.

Lyudmila Kimyagarova
Director

MACCC/TSHH P.R.O.M.P.T. trained-Level II
Speech-Language Pathologist
NYC License # 014994

PATIENT RESPONSIBILITY FOR PAYMENT POLICY

Patient Name_____ Date:_____

If we are participants in your insurance please see # 6.

1. Payment for services is due at the time services are rendered (unless payment arrangements have been approved in advance by the provider). We accept cash, checks and credit cards.
2. Returned checks will be subject to additional collection fees of $25.00 per check.
3. We will be happy to discuss your proposed therapy and answer any questions relating to your insurance to the best of our ability.
4. Please understand, however, that not all services are covered benefits in all contracts. Some insurance companies will not cover services that do not fit their definition of "medically necessary services".
5. If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us.

Insurance Authorization and Assignment

6. I_____understand that my insurance company will be sent an itemized bill for each session in accordance to reasonable and customary charges. I agree to assign benefits directly to Speech-Language Development SLP P.C. for all therapy services rendered. I also agree to remit any monies sent to me in error from my insurance company for services rendered to (patient's name) _____. I agree to pay for all services rendered should my insurance company deny payment for services rendered, and will be responsible for any deductible, co-insurance or co-payment, to be paid at the time of my visit.

_____ _____
(Date) (Signature)

7. For patients who pay privately or have out-of-network benefits, payments are due at the time of your visit. The fee for service for an initial evaluation is _____. The fee for all follow-up visits is _____. If requested, your therapist, will assist you in submitting claims to your insurance company.

_____ _____
Date Signature

Terms (for all patients): I have read and understand Speech-Language Development's Patient Responsibility For Payment Policy and hereby do agree to assume the obligation of payment to Speech-Language Development the total fee charged for services rendered if these services are not paid through insurance.

_____
Signature of Patient

I understand that it is my responsibility to obtain an insurance referral (if needed by my insurance company) through my Primary Care Physician. If this is not obtained by the date of my visit, I am aware that I will be responsible for payment

_____
Signature