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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 NOTIFICATION OF BILLING/CANCELLATION PROCEDURES

Please complete the attached registration/schedule form(s)

FEES

Fees are reviewed on an annual basis, and Speech-Language Development reserves the right to adjust the fees when it is deemed necessary. Thirty-day advance written notification will be provided if any fee increase is instituted.

BILLING FOR SERVICES RENDERED

All bills for services rendered will be sent out to the insurance carrier within thirty days of the service performed. Any co-payment, co-insurance, or deductible is due at the time of service. For patients paying out of pocket, payment is expected at the time of service unless other arrangements have been made. All invoices unpaid after 45 days will be subject to the maximum interest penalty/finance charge allowed by law. The Speech Language Development reserves the right to cancel treatment if payment for services is not received, and to use whatever means necessary including an attorney, small claims court, or collection agency in an attempt to secure payment.

Please note the cancellation policy, which excludes cases of illness:

CANCELLATION AND DISCONTINUANCE FROM SERVICES POLICY

1. In the event of a weekday cancellation, 24 hours notice is required prior to the appointment. Otherwise, you will be charged the full fee of the session. In addition, you will be charged the full fee for the session if you do not show for a *confirmed* appointment.

2. Sunday cancellations must be made 48 hours prior to the appointment. Any cancellations not adhering to this policy will be billed at the usual rate.

3. If a client with a regularly scheduled time slot misses or cancels three consecutive visits it will be considered that you are not in adherence or compliance with your plan of care relinquishing that time slot, and Speech-Language Development reserves the right to assign that time to another client.

I have read and agreed to the above policies and procedures.

Patient or Responsible Party Signature_____Date_____