



Financial and Insurance Policy Effective 1/1/2016

Billing

The usual and customary rate for services is billed to insurance. If we bill your insurance and you have a deductible, **the full amount applied to your deductible will be billed to you.** Unless your child has Medicaid or is in Babies Can't Wait, you are responsible for member expenses associated with each date of service.

_____ **Parent Initials**

RS Goldring Inc. is in-network with BCBS PPO/PAR/HMO plans. We will file all other insurance companies as an out-of-network provider. Deeming Waiver and SSI Medicaid are accepted. We will bill your insurance one time for each date of service, and following receipt of the insurance provider's response, we will bill you for any unpaid balance. You are responsible

_____ **Parent Initials**

RS Goldring Inc. accepts cash, personal checks, cashier checks, or money orders for payment of services. We also take credit cards for services. **We do require Credit Card Authorization form to be on file for every patient.** There is a \$25 fee for all returned checks. If a family receives a bill that is not paid within 30 days of receipt of invoice, there will be a 20% monthly finance charge added and your credit card on file will be charged. If your credit card on file is declined and payment is not rendered immediately, your therapy may be suspended and if necessary discontinued.

_____ **Parent Initials**

Babies Can't Wait

RS Goldring Inc. is a provider for the Babies Can't Wait Program (BCW) for qualified children under the age of three. There may be a family cost participation involved with the BCW program, which will be billed to the family monthly.

_____ **Parent Initials**

POTENTIAL COST PARTICIPATION RESPONSIBILITY

COST _____ %	SPEECH THERAPY	FEEDING THERAPY	SPEECH FEEDING/THERAPY
	\$ _____	\$ _____	\$ _____



Financial and Insurance Policy Effective 1/1/2016

Family Responsibility

Benefits will be verified upon receipt of your insurance information. Information obtained from insurance companies **is not always a guarantee of payment**. Families are ultimately responsible for payment for non-covered services. **It is imperative that families are aware of their insurance coverage and their potential responsibilities.** Families will inform RS Goldring Inc. of any changes regarding insurance or Medicaid services. Permission is granted for RS Goldring Inc. to bill and receive payment from insurance. Any payment sent directly to the family, intended to cover therapy services provided by RS Goldring Inc. should be given directly to RS Goldring Inc.

_____ **Parent Initials**

Attendance/Cancellation Policy

We strive to give our patients the best possible care and offer flexible scheduling. Your child's progress depends on your family's commitment to therapy. Therefore, attendance at your scheduled therapy appointment time is expected. However, if you need to cancel please to notify your therapist at least 24 hours prior to your scheduled appointment.

- ❑ **Private Pay and Insurance Patients:** After a one-time courtesy occurrence, a \$30 cancellation fee will be charged for the missed therapy appointment. ***Please note that insurance cannot be billed for this fee and you will be personally responsible for this charge.*** If this occurs more than twice in the calendar year, your speech therapy services will be in jeopardy of immediate suspension.

- ❑ **Babies Can't Wait Patients:** After a one-time courtesy occurrence of a missed appointment your speech therapy services will be in jeopardy of immediate suspension.

Many of our therapists work with medically fragile children and we don't want to carry sickness to other families, infect ourselves, or our own families. Please be respectful and cancel your therapy appointment if your child is sick. You will not be charged a cancellation fee for sickness and we will work to reschedule your appointment when your child is healthy. The Board of Health considers the following signs to indicate communicable disease/illness: **Vomiting, Fever over 100 degrees, Diarrhea, Sore throat, Rash/Swelling, Red, or running eyes.** Please be sure your child is symptom free for 24 hours before resuming therapy.

_____ **Parent Initials**

Parent/Legal Guardian Signature

Date