Anderson-Smith
SPEECH THERAPY LLC
Play with Purpose

Financial Policy Form

In order to help you determine your responsibility toward payment for services, please read the following and initial your preference for the method of payment for your account. Please notify the office if the status of your insurance changes.

Private Pay (please initial one):

___ I have insurance, but I wish not to file to my insurance company, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered. As allowed by SD state law, I am requesting a "Time of Service Discount" when I pay for my services on the same day that services are performed.

___ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered. As allowed by SD state law, I am requesting a "Time of Service Discount" when I pay for my services on the same day that services are performed.

Health Insurance:

___ I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment should my insurance company deny coverage for all or part of the claim submitted on my behalf. I understand that I will be required to pay all copays or coinsurance percentages as stated in my insurance plan contract.

_____

Patient name

_____ _____

Parent/responsible party signature Date