Capitol City
Speech Therapy, LLC

141 N Main Street
Fuquay-Varina, NC 27526

1520 Glenwood Avenue, Suite 201
Raleigh, NC 27608

Office: 919-577-6807 Fax: 919-577-6853
www.capitolcityspeechtherapy.com

PERMISSION TO EVALUATE / TREAT & PAYMENT TERMS

I hereby authorize **Capitol City Speech Therapy (CCST)** to evaluate / treat _____.

I understand that the results of the evaluation will be returned to the Client / Legal Representative, and the Physician referring the Client. I authorize CCST to release information, electronic or paper, about me as necessary to process claims for payment for services rendered, including health and liability insurance companies; agencies processing Medicare, Medicaid or worker's compensation claims; medical benefits plans, case managers or reviewers; or third parties responsible for paying claims for services provided to me. I authorize payment for those services to be made directly to the provider or practice. I also authorize to be contacted via text, email or standard mail to confirm appointments, provide therapy suggestions or any other pertinent information. I also agree NOT to video record during therapy sessions without written permission by my therapist.

As a courtesy, **CCST** will contact the insurance prior to initiating services and as needed throughout the course of treatment. Ultimately, I understand that it is my responsibility to determine and maintain insurance benefits. Benefits provided to me by **CCST** does not reflect a guarantee of payment by my insurance company for services rendered. I also understand that if I have a co-pay or a deductible to meet, I will make payment to **CCST** prior to evaluation and/or subsequent therapy sessions. This amount will be provided prior to the evaluation and/or therapy session. A receipt/invoice will be given at the time of payment. It is my responsibility to inform **CCST** of any changes to insurance, demographics, and/or name of Primary Care Physician thus if any expenses accrue because **CCST** was not notified I understand I will be responsible for payment of services.

CCST will send claims to the insurance company and wait for reimbursement. If the claim is denied based on the terms of the policy, **CCST** may require and/or request full payment of service rendered by the individual. We accept cash, Visa, Mastercard, Discover & personal checks. There is a return check fee. If payment is late, a 10% late fee will be added to the next bill. If you have not paid in full or arranged & honored a payment plan within 60 days, we will refer your account to a collection/audit bureau agency. They in turn will report your past due status to a Credit Report Agency. Any fees incurred by **CCST** for attorney costs will be your responsibility.

Medicaid does not cover for the services provided on the same day by two different providers (i.e. speech therapy on the same day) or if services are provided by an out of network provider. Therefore, I understand it is my responsibility to pay for any expenses that accrue when Medicaid denies payment in these situations.

By signing this form, it indicates that I have **read** and **fully understand** the terms listed above. This document has also been **explained** to me, and I fully understand all terms and responsibilities.

_____/_____/_____

Signature of Client / Legal Representative **Relationship** **Date**

_____/_____

Signature of Witness **Date**

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PERMISO PARA EVALUACION/TRATAMIENTO Y TERMINOS DE PAGO

Yo_____autorizo a Capitol City Speech Therapy a
(Nombre del Representante Legal o cliente)
Evaluar/tratar a _____.
(Nombre del cliente a evaluar)

Yo entiendo que los resultados de la evaluación serán entregados al Cliente/ Representante Legal, Doctor que recomienda y a la Compañía de Seguros (si se hace la petición). Yo autorizo a que Capitol City Speech Therapy libere información, electrónica o papel, sobre mí que sea necesaria para tramitar las reclamaciones de pago por los servicios prestados, incluida la salud y las compañías de seguros de responsabilidad; agencias de procesamiento de Medicare, Medicaid o las reclamaciones de compensación del trabajador; planes de beneficios médicos, administradores de casos o de los encuestados, o terceros responsables del pago de reclamaciones por servicios prestados a mí. Yo autorizo que los pagos por los servicios se hagan directamente al proveedor o a la práctica.

También entiendo que si tengo un pago deducible (co-pay) o un deducible a pagar, yo haré el pago a Capitol City Speech Therapy previamente a la evaluación y/o a la sesión de terapia subsiguiente. Esta cantidad será proveída previamente a la evaluación y/o a la sesión de terapia. Un recibo/ factura serán dada al momento de pagar.

Capitol City Speech Therapy mandara los reclamos a la Compañía de Seguros y esperaran por el reembolso. Si la transacción es negada basada en los términos de la póliza, Capitol City Speech Therapy podrá pedir el pago completo de los servicios rendidos al paciente o individuo. Aceptamos efectivo, Visa, MasterCard, Discover & cheques personales. Hay una tasa de retorno de verificación. Si el pago está atrasado, un 10% de cuota se añadirá a la próxima factura. Si no ha pagado en su totalidad o ha hecho arreglos y honrado un plan de pago dentro de 60 días, su cuenta será referida a una agencia de cobros. Ellos ahí informaran de su estado de atraso a una Agencia de Reporte de Crédito. Cualquier tasa incurrida por Capitol City Speech Therapy por costos de abogado será de su responsabilidad.

También mantendré informado a Capitol City Speech Therapy cuando y si la cobertura de la aseguranza cambia previamente a la evaluación y/o sesión de terapia.

Al firmar esta forma indico que he leído y entendido los términos establecidos previamente en esta forma. Este documento me fue explicado y doy fe de haberlo entendido.

_____/_____/_____
Firma del Cliente/ Representante Legal **Parentesco** **Fecha**

_____/_____
Firma de testigo **Fecha**