



## PAYMENT POLICY

Revised and Effective March 11, 2022

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Thank you for selecting Salubris Speech Therapy for your therapy needs. We are committed to providing you with quality services and have developed this payment policy regarding services rendered for clarity. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

**1. Insurance.** We participate in many insurance plans. If you are not insured by a plan that we do business with, payment in full is expected at each visit. If you are insured by a plan that we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage for speech-language pathology services.

**2. Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

**3. Proof of insurance.** All patients must complete our patient information form before receiving therapeutic assessment and/or intervention. We must obtain a copy of the responsible party's driver's license and current valid insurance to provide proof of insurance.

**4. Claims submission.** We will submit your claims, where possible, and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

**5. Coverage changes.** If your insurance information changes, please notify us before your next visit. If your insurance company does not pay your claim due to incorrect information, the balance will automatically be billed to you. Please update our office with any changes to your address or insurance policy.

**6. Nonpayment.** If your account is over 30 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice.

**8. Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time, as outlined on our Client Information and Consent Form. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment or notifying us of the need to cancel within the timeframe outlined in our agreement.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to client

\_\_\_\_\_  
Date

Please return to [info@KissimmeeSpeech.com](mailto:info@KissimmeeSpeech.com)