

NAME HERE M.A. CCC-SLP, TSSLD

Speech-Language Pathologist

STATE License Number XXXXX

Current Fee Schedule and Payment Policy *Revised 11/15

Fee Schedule	
Adult Language or Dysphagia Evaluation: 1 hour	\$xx
Adult Therapy Session: 45 min	\$xx
Pediatric General Evaluation: 45 min	\$xx
Pediatric Formal Evaluation with Report: 1.5 hours	\$xx
Pediatric Therapy Session: 45 min	\$xx
PROMPT Therapy: 45 min	\$xx
Vital Stim (NMES): 30 min	\$xx (includes electrodes)
AAC Programming	\$xx/hour
Parent Training: 45 min	\$xx
Screening: 30 min	\$xx
Consultation	\$xx/hour

Cancellation and No-Show Policy	
3 hours before session	xxx
Any cancellation after this time	xxx
No Show	xxx

For all cancellations, please call (xxx) xxx-xxxx.

Payment for Services

Payment is expected at the start of the session. Payment for late cancellations and no-shows will be required before beginning the next therapy session.

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Agreement to Terms of Payment

I, _____ (print name), acknowledge and accept full and complete responsibility for payment of all services rendered to my child or any child under my care by **NAME HERE**, M.A. CCC-SLP. I acknowledge that I have received written explanation of the fee schedule, cancellation policy, and payment policy and I agree to both. I understand that health insurance policies are an arrangement between my insurance company and myself, that all services rendered to my child or any child under my care are charged directly to me, and that I am personally responsible for payment. I understand that agreements regarding fee schedules, charges for cancelled appointments and late payment fees are between myself and **NAME HERE** and are not related to potential insurance coverage. I understand that **NAME HERE** may assist me in completing forms to aid in collecting insurance benefits for services that are billable, but ultimately it is my responsibility to complete and file such forms. I agree to the release by **NAME HERE** and/or its duly authorized agents of any information that is requested by my insurance company.

Date

Signature: _____
(Parent or legal guardian)

Print Name: _____