Shenandoah SOUNDstart, LLC
Pediatric Therapy Center

Office Policies

We are pleased to share our office policies, which are designed to ensure that your child gets the optimum benefit from our program. We believe in creating transparency and want to ensure families understand that our ability to continue to provide treatment to your child is dependent on timely payment for services rendered. All services rendered are ultimately the financial responsibility of the family. Please read carefully and indicate that you are in agreement. We welcome your comments and questions.

1. Insurance:

• A current prescription is required from your physician. **Initials: ______**

• Upload Prescription from your child's physician / or Please provide contact information to fax prescription to your doctor.
Doctor Name:__________ Fax Number:_________

• Shenandoah SOUNDstart, LLC is focused on delivering the highest caliber of care and therapeutic services. We contract and submit to several insurance companies as an amenity for our patients and their families, however the ultimate contract for insurance is between the insurance subscriber (primary party on insurance card) and the insurance carrier. **Please note that there is never a guarantee of coverage or payment from an insurance carrier and the ultimate financial responsibility rests on the patient's parent or legal guardian.**

Initials: ______

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• **"In-Network" Clients:** All deductibles, co-payments / co-insurance, and/or other payments are due at the time of service. As a reminder, pre-certification/authorization does not guarantee benefits or eligibility. As clinical providers being contracted with your insurance company, we have taken the responsibility of filing your charges directly to your insurance company. Some services may be denied by your insurance company secondary to plan, medical necessity, or other policy limitations. We will attempt to refile a denied claim on your behalf one time. If your claim is denied again, you are responsible for payment in full of all services denied or not covered by your insurance. You will receive a statement after 60 days of unpaid charges. **Initials: ______**

• **"Out-Of-Network" Clients:** Payment is due in full at the time of service. Clients may choose to speak with their insurance to explore if a "Gap Exception" may be granted, however, the responsibility rests on the parent or guardian.
Initials: ______

2. Additional Billing Information:

• It is the patient (parent or guardian) responsibility to provide Shenandoah SOUNDstart, LLC with up-to-date insurance information. Failure to provide updated information may result in denials and payment in full for all services will become patient responsibility. **Initials: ______**

For your convenience, Shenandoah SOUNDstart, LLCrequires that all clients have a credit card on file to cover any charges you may be responsible for. Credit cards will be charged for all applicable fees which may include but not limited to copays, coinsurance or cost of visit if deductibles have not been met at the time of visit. **Initials: ______**

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• **Overdue Accounts:** If your account is 30 days past due or greater, you will be subject to a recurring late fee of 5% of the due balance every 30 days it's past due. In addition, your child will be removed from the schedule and therapy will be on hold until the account is paid in full. Payment is due at the time of service and when a bill is received. You may be required to put down a deposit for future services. **Initials: ______**

• **Payments:** Payments for services can be paid by credit card or checks if you coordinate with the business office. Checks must be made to Shenandoah SOUNDstart, LLC. All charges associated with the collections of the bill become the responsibility of the responsible parties. Non-sufficient funds (NSF) checks are charged a $25.00 service fee. **Initials: ______**

• **Cancellations:** Cancellations must be made at least 24 hours prior to your child's designated therapy time. ***All appointments*** missed without contacting the clinic at least 24 hours before your child's scheduled appointment (Please refer to Cancellation Policy) will result in an automatic $50.00 late cancellation charge per session to the credit card on file. **Initials: ______**

• **Reoccurring Cancellations:** If your child is absent from therapy 25% of the time or more for two consecutive months, or there is an extended pattern of non-attendance, therapy will be discontinued unless special arrangements are discussed in advance. **Initials: ______**

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• **Consultation Fees:** We welcome the opportunity to answer your questions and discuss your concerns regarding your child. We also welcome the opportunity to collaborate with any family members or professionals who are involved in your child reaching their goals. Please note that brief discussions can take place during the first or last 10 minutes of your child's session. Please be advised that additional collaboration time or meetings outside of your therapist's treatment session, will incur additional expense at the hourly rate.

Initials: _____

By signing this agreement, I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. I have read, understand, and agree with the billing policy and procedures information presented above. Therapy will be initiated when the responsible parties have signed this agreement.

Child's Name: ________________________ Date Of Birth: ________________

Guardian Signature: ________________________ Date: __________________

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Assignment of Benefits and Consent for Treatment
Acknowledgement of Policies and Procedures

I authorize the release of all medical and/or further information necessary to process all claims pertinent to my medical care for services rendered by Shenandoah SOUNDstart, LLC, Pediatric Therapy Center.

I authorize treatment and procedures to be performed by Shenandoah SOUNDstart, LLC.

I authorize payment of medical benefits to Shenandoah SOUNDstart, LLC for services rendered and understand that my insurance plan does NOT GUARANTEE payment of my bill.

My signature below acknowledges that I understand that I am financially responsible and accept liability for all charges incurred at Shenandoah SOUNDstart, LLC.

By signing this form, I acknowledge that I have received a copy and am in agreement with Shenandoah SOUNDstart, LLC's Notice of Privacy Practices, Billing Policy, Cancellation Policy, and Consent for Release of Information.

Child's Name: _______________________***Date of Birth:*** __________

Guardian Signature: ________________________***Date:*** ___________

1330 Amherst St., Ste. D
Winchester, VA 22601

Phone: (540) 514-8486
Fax: (540) 301-3618