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| **PATIENT INFORMATION** | | | | |
|  |  | |  |  |
| Patient First Name | Patient Last Name | | Patient Date of Birth | M/F |
|  | | | |  |
| Parent/Guardian Name | | | | Relationship to Client |
|  | | | |  |
| Patient Street Address City State Zip Code | | | | |
|  | | | | |
| Phone Number(s) | | | | |
|  | | | | |
| Email Address(es) | | | | |
| **INSURANCE INFORMATION** | |  | | |
|  | |  | | |
| Policy Holder’s Name & Date of Birth | | Insurance Company | | |
|  | |  | | |
| Member# | | Group # | | |
|  | | | | |
| Policy Holder’s Address if different from above | | | | |
| **Fee Schedule** | | | | |
| $130.00 per hour for treatment sessions. The session is 45 minutes. | | | | |
| $130.00 per hour for meetings/consultations with parent and/or team. You will be notified of upcoming meetings and your approximate charge ahead of time. Although insurance can be billed, it usually never covers this type of billing. | | | | |
| $300.00 for 1 – 1/1/2 hour evaluations. $400 for 2 hour evaluations. If needed, additional time will be scheduled and billed separately. | | | | |
| $50.00 per child for 50 minute group treatment sessions. | | | | |
| I am a preferred provider for Aetna, Kaiser, Molina, Premera, and Regence. A copy of your insurance card is required at your first appointment. *Please notify me immediately of any changes of insurance to avoid payment delay*. I will bill your insurance company; however if payment is not received within 45 days, the balance will become your personal responsibility. | | | | |

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| **Cancellation Policy** | |
| * I understand that I must notify Lynnwood Speech and Language Services of all appointment cancelations 24 hours in advance. This will allow Lynnwood Speech and Language Services to service other children in need. * I understand that my account will be assessed a **$25 fee** for a late cancellation and a **$50 fee** for a no show to the appointment (to compensate SLPs for their time). This fee will be waived, if the appointment is rescheduled within 3 business days of the original appointment assuming that there are appointments available, which may be the case. * If you are late for an appointment, the therapy session will still end at the originally scheduled time unless accommodations can be made, (Full fee still applicable). If the clinician is late, then she will extend the session to ensure the full time is allotted. * Fees for missed appointments / late cancellations cannot be charged to insurance. * Missed appointments due to weather conditions or sudden illness will not be charged. * We ask for a 75% and greater attendance rate to keep your appointment slot. Please speak to your clinician if you require a different time slot that would better suit your needs. | |
|  | |
| **Signature** | **Date** |
| **PAYMENTS** | |
| * Deductibles will be due when they are processed by the insurance company. This will be 7 – 14 days after time of service. * Co-payments are due at time of service (Please see below for payment options) * Co-insurance is due the appointment after the billing has been processed and finalized. | |
| Initials: LSLS Initials: | |
| **PAYMENT OPTIONS** | |
| I elect to pay by cash, check or automated check each week or month. (Please circle preference.) | |
| Initials: LSLS Initials: | |
| I wish to pay using a credit card. There will be a service fee for each transaction. This will be done monthly and charged per explanation of benefits. | |
| Initials: LSLS Initials: | |
| I have a health savings fund debit card. This will be charged monthly. I understand that no shows and late fees cannot be charged to this type of card and is my own responsibility. | |
| Initials: LSLS Initials: | |
| I understand that services for my child can be suspended until payments are up to date. | |
| Initials: LSLS Initials: | |
| HIPPA Information provided on separate sheet. | |

If you have questions about the policy, please contact Susan E. Stewart at (425) 361-7046.