COMMUNICATION& FEEDING SPECIALISTS
• OF SOUTHEASTERN WISCONSIN •
CREATING PATHWAYS TO SUCCESS

Financial Agreement and Consent Form

PATIENT'S FULL NAME: _____ **DATE OF BIRTH:** _____

HOME ADDRESS: (street address): _____

(city) _____ **(state)** _____ **(zip)** _____

HOME PHONE: _____ **MOTHER'S CELL:** _____ **FATHER'S CELL:** _____

MOTHER'S NAME: _____ **[ ] lives with child** **DATE OF BIRTH:** _____

FATHER'S NAME: _____ **[ ] lives with child** **DATE OF BIRTH:** _____

PRIMARY EMAIL: _____

INSURANCE INFORMATION:

POLICY HOLDER: _____ **DATE OF BIRTH:** _____

SOCIAL SECURITY #: _____ **EMPLOYER:** _____

INSURANCE COMPANY: _____

RELATIONSHIP TO PATIENT: _____ ***I have given CFS a copy of insurance Card ☐***

Are you currently in collections? Yes / No

Consent to Treat

☐ I, _____, the parent/legal guardian of _____, hereby request and consent Communication & Feeding Specialists to perform treatment and care as prescribed by a physician and/or recommended by a speech-language pathologist. I understand and am informed that, as in the practice of medicine, speech-language and feeding therapy may have some risks. I understand that I have the right to ask about these risks and have any questions answered about the condition, prior to treatment. I acknowledge and agree that a parent or legal guardian must be present during each treatment session. I consent and authorize Communication & Feeding Specialists to administer treatment under the direction and supervision of a certified speech-language pathologist. I am aware that gross motor play is often encouraged during therapy. Use of swinging, running, climbing, and jumping assist with a variety of skills. I consent to use of gross motor play and exempt therapist(s), employee(s), and owner(s) of Communication & Feeding Specialists, from any injury resulting from this type of play. Patient/Parent Initials:_____

Consent to Bill

☐ I hereby authorize Communication & Feeding Specialists to bill my insurance company for direct reimbursement of therapy services rendered. Unless otherwise noted, benefit payment will be assigned directly to Communication & Feeding Specialists. I understand that patient/patient's family is responsible to pay all fees accrued, regardless of insurance verification or anticipated insurance coverage, if insurance company refuses to pay provider a portion of the fees or in full, **I agree to pay all fees within 30 days after bill has been mailed. In the event of a returned or invalid payment, as well as an unpaid balance over 90 days, I agree to pay any and all additional associated banking, legal, and/or collection fees.** If I purchase any educational supplies from Communication & Feeding Specialists, the cost of these supplies will be billed directly to me and not submitted to my insurance company.

☐ **I understand that it is my responsibility to fully understand my insurance benefits prior to my child receiving therapy services**. I understand that all insurance plans are different and it is impossible for Tosa-Speech Language Pathology, LLC to know the specifics of my plan and/or if my plan will reimburse for services received. Regardless of insurance coverage, I agree to pay all fees accrued for services received.

☐ Unless a specific payment plan has been agreed upon and put into writing, a 5% late fee will be charged after 60 days of no payment. After 90 days of no payment Communication & Feeding Specialists will contact a credit agency and /or report uncollected past due charges to the Internal Revenue Service. If your account would need to be turned over to a collection agency due to non-payment, a fee of 35% of your total bill will be added to the total amount owed. I understand that I will be charged a fee of $25.00 for any checks returned by the bank for insufficient funds. Patient/Parent Initials:_____

Cancellation Policy

☐ Please arrive on time for your scheduled appointment. If you are going to be late, please call to notify us. Please understand that if you are late to an appointment, you may receive a shortened therapy session. Your appointment will be marked as a "no show" if we do not receive notice 24 hours in advance. Same day cancellations will be charged a $35 cancellation fee per day. After three "no show" appointments, patient will be removed from our schedule. It is your responsibility to contact us to resume services. At that time, every attempt will be made to reschedule; however, patient may need to be placed on a waitlist. In addition, consistent cancelations/rescheduling may result in a loss of regularly scheduled time slot or temporary discharge from services.

Patient/Parent Initials:_____

I have carefully read and fully understand this Financial Agreement and Consent Form, and have had the opportunity to discuss it with the treating therapist. I HEREBY CONSENT AND GIVE PERMISSION FOR EVALUATION/TREATMENT AT COMMUNICATION & FEEDING SPECIALISTS.

Patient's (or) Guardian's Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Witnessed by: _____ Date: _____