Articulate Speech and Language Therapy, LLC
4325 Laurel Street, Suite 100
Anchorage, AK 99508
(907) 569-5665

Financial Agreement

Client Name: ________________________________ **Date of Birth:** ______________________

Cancellation/Attendance policy

I understand that my child has a standing appointment for treatment services. His/her attendance is expected on the days for which he/she is enrolled.

I understand that there is a cancellation/no show charge of $50.00 if I fail to give the Articulate Speech and Language Therapy, LLC staff at least a 1-hour notice that my child will be absent for any reason, including illness. If my child will be absent on any given day, I will not be charged this fee if I give adequate notice. I understand that this fee cannot be billed to my insurance and I accept full responsibility for all cancellation charges and acknowledge that they are **due at my child's next appointment**.

Responsibility for Payment/Authorization to Bill Insurance

If insurance will not be filed, an individual payment plan will be required *before* the start of treatment. Articulate Speech and Language Therapy, LLC has agreed to file insurance claims for my family. However, the balance is my responsibility regardless of what my insurance company pays (Medicaid excluded by federal law). ***Payment is due upon receipt of invoice.***

I authorize Articulate Speech and Language Therapy, LLC and its associates to release any information required by my insurance company for the processing of all medical claims filed on my child's behalf.

I authorize my insurance company to pay benefits directly to Articulate Speech and Language Therapy, LLC for claims filed on my child's behalf. If my insurance company pays a fee that I have already paid, I understand that I will be reimbursed by Articulate Speech and Language Therapy, LLC.

I understand that Articulate Speech and Language Therapy, LLC is a "preferred provider" for Alaska Medicaid, Premera Blue Cross Blue Shield and TriCare/TriWest insurances ***only***. Therefore, ***all*** charges not covered by my private insurance company are my own responsibility (Medicaid excluded by federal law).

I understand that I may be required to assist Articulate Speech and Language Therapy, LLC in the processing of claims by my insurance company. If my insurance company has not processed a claim within 30 days of submission by the Articulate Speech and Language Therapy, LLC, I may be requested to contact my insurance company to follow-up on the processing of the claim(s).

I understand that all accounts are to be paid upon receipt of invoice. Interest will be charged on outstanding balances exceeding 30 days, at a rate of 10% per 30 days, unless payment arrangements have previously been made. I also understand that if my account is turned over to a collection agency I will be responsible for all charges incurred in the collection process.

I acknowledge that I have read, understand and accept the above financial agreement.

________________________ ________________________ ____________

Parent/Guardian Signature Parent/Guardian printed name Date