Patient Financial Responsibility Disclosure

Your signature below forms a binding agreement between the offices of ACT Speech Therapy, PLLC and the individual who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of bills. All charges for services rendered are due and payable at the time of service.

Payment Policy

Payment is payable at the time of service, via cash or check. Checks should be made payable to ACT Speech Therapy. I do not bill insurance directly. If appropriate, I can provide a superbill at the end of each month with applicable medical codes, service dates, and fees paid for parents seeking reimbursement. **A $25 fee will be charged for each returned check.**

Please review the attached Office Policy document regarding attendance, cancellations, and additional fees.

By signing below, you agree to accept full financial responsible as an individual who is receiving services, or as the responsible party for minor patients. Your signature verifies that you have read the above payment policy, that you have read the attached office policy, that you understand your responsibilities, and agree to these terms.

Child's Name (Please Print):
_____

Responsible Party Name (Please Print):
_____

Responsible Party Signature:
_____