



ATTENDANCE POLICY

We strive to offer you high quality speech-language pathology services. Every attempt is made to schedule your services in a timely manner and when possible, at your convenience. Regular attendance is important to make progress and achieve success in therapy.

We must enforce the following attendance policy for every client:

Treatment sessions must begin at the scheduled time. Late arrival may be subject to the late cancellation or no-show fee.

Initials_____

24 hour notice is required to cancel a session. In case of illness or emergency with notification of less than 24 hours a make-up session may be completed within 4 business days to waive the penalty. An emergency does not include a vacation, minor illness (unless negotiated with the provider), ineffective appointment scheduling or transportation issues. The make-up session will be completed in addition to regularly scheduled therapy.

Initials_____

A make-up session might not be with your primary therapist or at your preferred day/time.

Initials_____

If no make-up session is completed, a \$50 late cancellation fee will be charged. This fee is not the responsibility of your insurance company; it is solely a patient responsibility.

Initials_____

Each family/client will be allowed one late cancellation without a penalty. Should this occur, your therapist would inform you that there is no penalty but future late cancellations or no-show appointments will incur a \$50 fee.

Initials_____

Any late cancellation or no-show fee must be paid in full prior to attending future appointments.

Initials_____

By signing below, I agree to the terms of this contract and understand the importance of consistent attendance for successful therapy.

Signature of patient or legal representative

Date



FINANCIAL RESPONSIBILITY

I hereby give Sonos Neurotherapies, LLP authorization to file claims with my insurance company for services rendered on my behalf. Any claims that are not paid or authorized by the insurance carrier will be my responsibility. If the insurance company does not issue payment within 30 days of initial filing, I recognize that I am responsible for following up with the insurance company for payment of services.

I understand that it is my responsibility to verify that my insurance company will cover services provided by Sonos Neurotherapies, LLP and to monitor and keep track of my financial responsibility for therapy services.

- ❖ Our financial contract is with you, not with your insurance company.
- ❖ You are responsible for notifying Sonos Neurotherapies immediately if there are any changes with regard to your insurance benefits or coverage. Failure to do this may result in lack of coverage for therapy.
- ❖ We bill your insurance company at your request. If we are not in contract with your insurance company, you may be subject to out-of-network costs.
- ❖ For patients with insurance coverage, co-payments are due at the time of service (we accept check, credit/debit cards and exact amount of cash)
- ❖ Any no-show or cancellation fees are not the responsibility of the insurance company and must be paid by you.
- ❖ Coinsurance and deductible amounts are due when EOB statements are received
- ❖ If your portion of payment is not made within 60 days, your appointments will be placed on “hold,” and you may lose reserved appointment spots until the balance due is paid in full
- ❖ All returned checks will incur a \$30 service fee.
- ❖ Verification of benefits is not a guarantee of payment by the insurance company.

I have read and understand the financial policy of Sonos Neurotherapies, LLP and I hereby accept all responsibility for the evaluation and treatment costs incurred. I, the undersigned, understand the above conditions to be a legally binding agreement.

Signature of patient or legal representative

Date

Relationship to patient