SPEECH PATHWAYS, P.C.

CLIENT FINANCIAL RESPONSIBILITY

Payment is required at time of service. If for any reason we are unable to verify insurance eligibility prior to office visit, ***you are responsible*** for full payment upon services being rendered. ***You are responsible*** for the full balance due, if your insurance does not provide coverage for speech therapy or fails to pay the amount in full.

Verification of benefits is not a guarantee of payment. **You are responsible** for the initial authorization required by your insurance and any charges not covered by your insurance. Benefits are subject to eligibility at the time of service. All specific plan provisions, exclusions and limitations will be applied at the time the claim is processed.

I understand **I am responsible** and will pay for all the following charges before my child or I attend the next therapy session:

CO-PAYMENTS – due at time of service
LATE CANCELLATION - $85
RETURNED CHECKS - $35.00/check
COPIES – $10 annual fee
NO SHOW CHARGES – $85

Please indicate your preference and sign below. (Check one only)

____ I agree to directly pay Speech Pathways, P.C. for all services.
____ Speech Pathways, P.C. should bill my insurance carrier.
____ Speech Pathways, P.C. will provide me the information to bill my insurance carrier.

I, the undersigned, understand the above conditions to be a legally binding agreement.

______________________________________ ______________________________

Client/Guarantors Signature Date signed

Medical Center Location, 2509 Dorrington, Houston, TX 77030, Ph: 713-660-8232, Fax: 713-660-0473
Katy Location, 16365 Park Ten Place, Houston, TX 77084, Ph: 281-492-0254