



Central Delaware Speech Language Pathology, Inc.

*Specializing in the Diagnosis and Treatment of Speech-Language Disorders
ASHA Certified, Licensed in Delaware*

Central Delaware Speech-Language Pathology is committed to partnering with you in your child's care. We have identified the following points as road blocks to effective running of the practice and request your help to resolve them.

As an Insurance Policyholder I agree:

1. I understand I am ultimately responsible for any cost that is not covered by insurance.
2. I understand that I am responsible for knowing and understanding my own benefit plan, including what services and codes are covered by my insurance company.
3. I understand that I am responsible for knowing and informing the staff of Central Delaware Speech-Language Pathology any changes to my insurance plan. If failure to inform CDSLSP of any changes results in a denial of claims, I am responsible for payment of the claims.
4. I am responsible for providing CDSLSP, in a timely manner, with any necessary paperwork in order to submit insurance claims. If failure to provide CDSLSP with the necessary paperwork results in denial of claims, I am responsible for the payment of the claims.
5. In the case of a payment rejection, for any reason, CDSLSP requires the policyholders' payment **before** any additional services will be rendered. We require **all** co-pays at the time of service, and co-insurance immediately upon receipt of the bill.
6. I understand that I am responsible to pay any balance on my child's account immediately. In case of failure to do so, my child's appointments will be discontinued until the balance is paid.
7. I understand that if a balance on my child's account remains unpaid for 30 days or more, the account will be turned over to a third party collection agency.

Attendance:

1. I understand that all appointment cancellations and/or rescheduling **must** be made at least 24 hours prior to appointment.
2. I understand that after 1 cancellation with less than 24 hours notice within calendar year may result in billed time for missed appointments and/or changes to my child's future appointment schedule.
3. I understand that after 1 no call/no show within a calendar year may result in billed time for missed appointments and/or changes to my child's future appointment schedule.

Parent/Guardian Presence:

1. I understand that I **must** remain in the building throughout my child's therapy session in case of emergency or if assistance is needed. **No exceptions.**
2. I understand that CDSLSP staff is not responsible to ensure that any child, whether patient or sibling, is supervised. Supervision is solely my responsibility as a parent or guardian.