Lambert Speech & Language Services
17 Main Street ~ Suite 2 ~ P.O. Box 273
Belchertown, MA 01007
413-218-8526 ~ Fax 413-323-8443
www.lambertspeech.com
info@lambertspeech.com

FINANCIAL POLICY

Thank you for choosing Lambert Speech and Language Services as your child's health care provider. We are committed to your child's treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatments.

FULL PAYMENT (INCLUDING COPAYMENT) IS DUE AT THE TIME OF SERVICE UNLESS OTHERWISE AGREED UPON. WE ACCEPT CASH AND CHECKS.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Any accounts with amounts 30 days overdue are subject to a finance charge of 1.5 % per month. The adult accompanying a minor/child and the parents (or guardians of the minor) are responsible for full payment on the day of service.

I have read and understand and agree to all fees for professional services rendered in my child's behalf. I understand that payment of services are my personal responsibility and are due and payable at the time services are performed and agree to pay for them at that time. It is my responsibility to know my insurance benefits; therefore, I am responsible for any non-covered services. I also understand and agree that failure to pay for these fees can result in additional cost to me due to collection action that may have to be taken. This includes unmet deductibles, co payments and/or support or supplies which my insurance does not cover. If I am paying privately for these services, I agree to pay the discounted rate of $85.00 per visit/session if paid at the time of service (40 - 45 minutes) and / or $250.00 for the initial evaluation (1 ½ - 2 hours). I understand that if additional appointments are necessary to complete my child's initial evaluation, I agree to pay for additional sessions at the discounted rate of $85.00 per visit/session if paid at the time of service (40-45 minutes) and/or insurance co pays for each additional visit as applicable and required by my insurance company.

X_____ **Date:** _____
(Signature of Patient/Responsible Party)

I hereby authorize and direct Lambert Speech and Language Services to release all information necessary to process this claim and/or to provide necessary information to other legal or health care providers.
X_____ **Date**_____
(Signature of Patient/Responsible Party)

I hereby authorize and direct my insurance carrier to apply all benefits which may be due me according to my policy, directly to Lambert Speech and Language Services to be applied to my account.
X_____ **Date:** _____
(Signature of Patient/Responsible Party)

X _____ **Date:** _____
(Signature of Witness)

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

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