Jill Shook, MS, CCC-SLP
Owner, Jill Shook Therapy, LLC
412-436-9757
jillshookslp@jillshooktherapy.com

OFFICE USE ONLY	
ID	
DATE	
OTHER	

PAYMENT POLICY

Thank you for choosing **Jill Shook Therapy, LLC,** for your child's speech-language services. I am committed to helping your child reach their communication goals! My services, including travel and specialized therapy materials, depend on the timely payment of accounts. **Please read and sign this policy to indicate your understanding and agreement.**

INSURANCE: Your insurance policy is a contract between you and your insurance company. I will bill your company for any outstanding balances for speech therapy services. Please be aware that some, and perhaps all, of the services provided by **Jill Shook Therapy, LLC** may be non-covered services and not considered reasonable, customary and/or medically necessary under your medical insurance plan. You may seek reimbursement for these services directly from your insurance company. If you are unsure about the process for filing a claim, I recommend that you call the customer service number on the back of your insurance ID card.

Speech-language services provided by **Jill Shook Therapy, LLC** will be considered in-network by your insurance company if I am a provider under them. **I am not responsible for any charges your insurance company considers to be in excess of reasonable or customary fees as well as those considered medically unnecessary.**

By the execution hereof, the undersigned acknowledges his/her/their responsibility to pay any amounts not paid or reimbursed by insurance. The undersigned specifically accepts all financial responsibility for all services provided to the herein named client by **Jill Shook Therapy, LLC** and understands that regardless of what the insurance company agrees to pay, the undersigned will be responsible for the balance. Said balance will be paid without regard to the status of processing by the insurance carrier.

USUAL AND CUSTOMARY RATES: I am committed to providing the best treatment for my clients and I charge what is usual and customary for our area and for my services. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

BILLING: Sessions are billed as they are completed. For example, if your child will be seen once per week, the bill sent to insurance will include 4-5 therapy sessions, depending on the number of weeks in the given month. If your payment is not received from the insurance company within 6 weeks, services will cease until payment is received.

CANCELLATIONS: All canceled appointments will be rescheduled if possible. Missed appointments jeopardize my travel and planning time, as well as other clients' therapy time. Please be considerate and cancel appointments within a reasonable amount of time. Please review the policy below:

- Canceled by you **with** prior notice (24 hours): rescheduled session at a time that the therapist is

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available.

- Canceled by you **without** prior notice ("no show"): session will be charged at 50% of the normal session rate.

- Canceled by the therapist: rescheduled session at a time that the therapist is available.

If you are not prepared for therapy at the scheduled appointment time, the session will end at the regular session time and you will be responsible for the full session fee.

PAST DUE ACCOUNTS:
Private Pay: Please make timely payments to your account to ensure continuation of services for your child.

In the event that an account becomes past due (i.e., not paid by the next session), your child's speech-language services will cease until payment is received.

METHOD OF PAYMENT: I accept the following forms of payment:

- Bill to insurance
- Cash: Exact change required.
- Personal Check: Make payable to **Jill Shook Therapy, LLC**. Returned check fee: $35.

Please indicate your understanding and agreement to this payment policy by signing below.

Thank you for taking the time to complete this form! I look forward to working with you!

____ ____________________
PARENT/GUARDIAN SIGNATURE DATE