Gorge Falls Therapy SLP, OT, PLLC

Therapy & Financial Agreement

Welcome to Gorge falls Therapy. All of our providers hold current NYS Professional Licensure. Our SLP's carry teaching certification as well as Certificate of Clinical Competence from the American Speech and Language Hearing Association. Our Occupational Therapists are affiliated with the American Occupational Therapy Association (AOTA).

THERAPY AGREEMENT

The provider will provide services agreed upon by both parties.

Parent/clients are responsible for bringing goals to therapy.

Parent/client will not hold providers or Gorge Falls Therapy responsible for any claims/damages of any kind for injury or person(s); damages or loss of property arising directly or indirectly out of participation of therapy sessions.

COVID-19 Informed Consent:

If you have agreed to face to face; in person sessions; you agree to abide by GFT required precautions to minimize the spread and exposure to the virus. GFT precautions follow local, state and federal orders and guidelines. If at any time you feel uncomfortable with in person sessions, a change to teletherapy can be arranged.

PAYMENT AGREEMENT

Client/Parent agrees to pay for services at the time of service (unless an alternate payment agreement has been arranged in advance). Checks are payable to Gorge Falls Therapy. We accept cash, check or credit card. Invoices may be received from Gorge Falls Therapy Wave billing services.

We will submit a claim directly to your insurance if your insurance is one that we contract with. A copy of the insurance card will be required. Coverage will need to be verified and authorization requested prior to visits. Patient is responsible for Co-pays, co-insurance and or deductible fees. Authorization is not a guarantee of payment. Patient is responsible for fees not covered by insurance.

If we are not in network with your insurance carrier and you would like to submit for reimbursement to your insurance carrier, we will provide a superbill of your visit to you as a courtesy.

A $25.00 charge will be applied to any bounced check.

A late payment of 5$ will be added to your bill for every week past due date.

Non-Payment-If your account becomes delinquent, you will be responsible for any costs involved in collection on your account, including but not limited to interest charges, late fees, court costs, attorney fees and collection costs. A collection agency may be used to collect on delinquent accounts. Insurance benefits are between you and your carrier. You are ultimately responsible for payment on your account.

ATTENDANCE POLICY

Cancellation: Please contact your provider with requests for cancellation 24 hours in advance.

No show or cancellations made less than 24 hours in advance of scheduled appointment will be billed the full amount for the missed visit. A makeup session may be available depending on provider's availability.

Gorge Falls Therapy reserves the right to end therapeutic services at any time and/or if the number of missed/cancelled sessions are in excess 3 missed sessions without adequate notice.

Parent/Client reserve the right to cease services with Gorge Falls Therapy given a 7-day notice prior to the last scheduled therapy session.

Make up policy: Gorge Falls Therapy will attempt to provide make up sessions for any missed sessions that are cancelled by provider. Clients have the right to deny offered make ups sessions. Missed sessions due to client absence can be made up depending upon provider availability and discretion.

I have read the therapy agreement policy and agree to its terms.

CONSENT FOR SERVICES

I agree to have the following services provided by Gorge Falls Therapy:

_____Speech Therapy _____Speech & Language Evaluation

_____Occupational Therapy _____ Occupational Therapy Evaluation

_____ Feeding Evaluation _____Parent Coaching Workshop

and agree to the above stated **Payment and Attendance agreement**.

_____(print name)

Signed_____ Date_____

Communication Preference

I give permission to receive communications by: (circle all that apply)

Mail phone email fax text message Facebook messenger

Signature Date

Client Information:

Client Name:_____

Date of Birth:_____

Parent Caregiver:_____

Address: _____

_____

Phone: _____

Email:_____

Consent to Bill Insurance for Services

Subscriber Name: _____
Subscriber DOB: _____
Subscriber Address:
_____
_____

Phone: _____

Insurance Carrier: _____
Subscriber Number: _____
Primary: Y / N Secondary: Y / N Managed Care: Y / N Third Party: Y / N
Co-payment: _____ Co-insurance_____ Deductible_____
Out of Pocket Responsibility: _____

I give Gorge Falls Therapy SLP, OT, PLLC my consent to access my or my child's insurance information and bill accordingly for services provided.

Print name **Date**