

## THERAPY POLICIES

### THERAPY SESSIONS

If a parent or responsible party chooses to wait in the waiting room during a session, they will be called in to speak with the therapist about the child's progress and homework during the last 5-7 minutes of the session. If the person bringing a child to therapy is not the parent (babysitter, grandparent, etc.), we will update them regarding the child's session only if we have a release of information signed for that party.

Occasionally, parents are unable to attend sessions and their child attends with a sitter, relative, etc. In this situation, we are unable to make calls on a weekly basis to parents to provide updates. If a parent would like an update they have some options. They may attend sessions from time to time, they may call us for a debriefing of 10 minutes or less, without a charge or they may schedule and pay for a 30-minute meeting or longer telephone debriefing with the treating Speech Pathologist.

We will not become involved in or discuss domestic disputes regarding custody of a child, responsibility for bringing the child to therapy and payment of the child's account. Please let us know if your child's behavior is being affected by any family event or situation.

We must conclude promptly at the end of our scheduled time in order to maintain the timeliness of our appointments. If you have extra questions on any day, please let the therapist know at the start of the session so enough time for answers can be saved at the end of the session. If you do not notify us that you are requesting additional time for questions we will have to address your questions at our next scheduled session. Kindly do not ask our staff to extend your session.

You may be asked to purchase equipment for your program (i.e. oral motor tools, feeding devices, etc.).

\*\*An adult must remain ON SITE for the duration of a child's session in case of emergency, toileting issues, etc. Our staff will not toilet a child. Let our staff know if you will need to leave the office to go outside so we can easily find you if any issues arise. Please do not leave to run errands.

### CANCELLATIONS, LATE ARRIVALS & CANCELLATION FEES

Cancellations must be made with 24 hour notice or a "cancellation fee" will be charged. Insurance cannot be billed for this fee. Advance notice allows us to offer the appointment to another client who may need to make up an appointment and notifies the Speech Pathologist not to prepare for your session.

Cancellations for a client illness must be made by 9 am the day of their appointment. Any call outs for illness made after 9 am will be charged a cancellation fee. Cancellation for the illness of a parent, spouse, child or sibling will also incur a cancellation fee.

Cancellations for any reason (traffic, illness, family emergencies, car breaking down, home emergencies, summer vacation, holiday parties, school events, sports, missing holidays that we are open, etc.) will count toward our attendance requirements.

Clients are offered one attempt to make up a cancelled appointment, within a 2-week period, to reverse the cancellation fee. We make every attempt to re-schedule appointments, however we cannot guarantee a make-up appointment will be available that fits your scheduling needs. We try to re-schedule appointments if a therapist misses work for any reason.

If you re-schedule a cancelled appointment and do not attend it, you will be charged a cancellation fee for both missed appointments. If your therapist must re-schedule your appointment and you do not attend it, you will be billed a cancellation fee. Cancellation fees must be paid at your next scheduled appointment.

If you are late to an appointment, we will need to conclude that session at the usual time. We are unable to bill insurance for a session if you are late by 15 minutes or more and a cancellation fee will be charged. If your therapist is running late for any reason, you will be given your full session time. We regret any resulting inconvenience to your personal schedule.

#### **WAITING ROOM & TREATMENT ROOM ETIQUETTE**

If your child soils their diaper or pull-up, we ask that you change it quickly. We are unable to open most windows in our office to ventilate the rooms. Odors make for an unpleasant environment for our clients and staff. If you do not have a change of diaper or pull-up we will ask that you clean them up as best you can in the rest room. If the odor persists, we will need to terminate the session.

Cell phone use is not allowed in the waiting room or the treatment rooms. If you must answer or make a call, kindly use your phone in the hallway or outdoors.

Food or drink is not allowed in the waiting room. We have no housekeeping services to clean up messes during the day and spills leave stains and odor. If you need to eat or drink please do so before session or in your vehicle.

We have staff & patients with significant allergies and allergy-triggered asthma. With this in mind, if you wear perfume or cologne that triggers the asthma or smell of smoke, which triggers the asthma, you will be asked to not sit in the therapy room. Kindly understand that this is a serious medical condition that debilitates certain staff & patients and is NOT a personal criticism.

We do not allow behaviors in our waiting room that may injure our child or others nor do we allow behaviors that might disturb the work of our staff and our neighbors in the building. Kindly do not allow your child to climb or jump on chairs, throw toys, slam doors, scream, fight, bite or bang their feet on the floor in a manner that is disruptive. Our staff may provide gentle reminders from time to time if the little ones forget.

Adults may not yell at, curse at, threaten, belittle or speak abusively to our staff or therapists if they are displeased with our policies, fees, their child's progress, scheduling, insurance denials, etc. in our waiting room or on the telephone. This creates an unpleasant and uncomfortable situation for all involved. It frightens and upsets our staff and clients. If you do this in the office, you will be asked to leave the premises. If you do this by telephone, our staff has been instructed to terminate the call. You may call back when you can speak calmly with us.

#### **ATTENDANCE POLICY**

You are asked to maintain attendance that keeps you in good standing with our Attendance Policy. This allows us to maintain a consistent and quality therapy program. To maintain your or your child's skill level and to avoid regression of skills, we ask that you maintain consistent attendance.

Clients attending two sessions weekly may miss a maximum of 4 visits within any 3 month period.

Clients attending one session weekly may miss a maximum of 3 visits within any 3 month period.

**EXTENDED ABSENCES:** If you are going to be absent for two or more weeks, you will be asked to vacate your therapy appointment slot and it will be given to someone else. You may call us when you return to be placed on our waiting list. Extended absences include absences to travel abroad, vacations, etc.

**HOLDING AN APPOINTMENT SLOT:** Families have asked in the past if they can pay to "hold" their slot during extended absences and we will make that accommodation for you if you do not want to exit your therapy

appointment. You may pay our usual fee for each session not attended that you want us to hold for you until you return. Insurance cannot be billed to hold a session.

Clients may not use their allowable cancellations consecutively in order to “hold” their appointment slot during an extended absence. For example, this means (for clients attending one session per week) that you may not use three consecutive misses to hold your appointment while you go on vacation.

Finally, families who miss two consecutive sessions, without calling us and do not return our calls regarding the absences, will be removed from our schedule. We will assume that if you are terminating your relationship with our facility. You will, however, be charged the full amount of your final two sessions.

### **SPECIAL MEETINGS**

If you request a special meeting for any reason (i.e. to discuss progress, treatment planning) there is a charge for that session at our usual rate. We are unable to bill insurance for a meeting.

If you schedule a meeting, it will be held during your Speech Pathologist’s office time. You may not use your child’s scheduled therapy session to hold a meeting. The week of the meeting, your child will need to attend his or her regularly scheduled appointment in addition to you attending the meeting.

If you schedule a meeting and do not attend you will be billed for a cancellation fee as the therapist has prepared for the appointment and has scheduled time to see you. Additionally, if your child misses his or her scheduled appointment that week a cancellation fee will be applied.

We do not attend IEP meetings or develop IEP goals for families. We will speak with your child’s school-based Speech Pathologist on the phone if a written consent is signed by the parent or guardian. There is no charge for calls of 10 minutes or less. A fee will incur on calls over 10 minutes in length. If you ask us to write in a communication book with a school-based Speech Pathologist, we will do so during your child’s appointment.

In the past our Speech Pathologists have been subpoenaed in lawsuits that families file against doctors, medical institutions, etc. If your lawsuit requires us to attend a deposition or trial appearance you will be billed for the following:

- Our hourly rate for time spent preparing for the deposition or court appearance.
- Our hourly rate for travel to and from the site.
- Our hourly rate for the time spent talking with lawyers, going to court, etc.
- Our hourly rate for our waiting time.
- Our legal costs, if applicable

### **HOLIDAY CLOSURES**

Our office will be closed for the observation of the following holidays:

- Presidents Day
- Memorial Day
- Fourth of July
- Labor Day
- Thanksgiving and the Friday following
- Christmas Eve and Christmas Day
- New Year’s Eve and New Year’s Day

Please do not assume we are closed on days you may have off from work or school. We are opened during many of the typical school holidays. If you are unsure if we will be open or closed on any particular holiday, kindly call us to inquire.

### **CANCELLATIONS BY YOUR SPEECH PATHOLOGIST**

If your therapist is away for any reason other than illness, you will be notified in advance. We will attempt to reschedule your appointment.

When a therapist is on vacation or jury duty, it is impossible for us to reschedule the entire caseload.

In emergency, medical situations such as migraine, vomiting, pain, long-term treatment or examination for medical condition such as diabetes, pregnancy-related illness and medical visits or dental emergencies we ask your understanding and patience regarding illness related cancellations. We will attempt to re-schedule your appointment.

### **INSURANCE BENEFITS & DISPUTES**

All clients using insurance benefits are asked to contact their carrier directly regarding their benefits. Our staff cannot be responsible for attempting to interpret your benefits. We are responsible for collecting your deductible amounts, co-payments, co-insurance payments or the cost of denied claims.

Our Speech Pathologists identify the signs and symptoms of the client's disorder. They cannot change a diagnosis to one that is incorrect upon your request. Many insurance representatives blame the carrier's denial of payment on the Speech Pathologist "not using the right code". To change a diagnosis code is unethical and fraudulent. Your Speech Pathologist could lose her license and certification and pay large fines for doing this.

Professional Speech Services, LLC and its employees are not responsible for the determination of payment or denial by your insurance carrier. We recommend you contact your carrier directly with questions regarding their determination. We cannot be actively involved in patient disputes with insurance carriers or provide additional letters for the dispute.

### **TERMINATION OF THERAPY**

The following reasons may be cause to terminate our relationship with a client.

- Behavior of a client (tantrums, physical aggression, refusing to follow directions or recommendations, verbal abuse, fleeing the therapy room, hiding, falling onto the floor). An occasional "bad day" is anticipated for all clients however, if the behavior is ongoing and cannot be changed, we will recommend changing therapists within the facility. If this is not successful in improving the behaviors, you will be referred to another facility.
- Behavior of a parent.
- Non-compliance with our Attendance Policy.
- Abuse of our re-schedule policy.
- Repeatedly not paying an account.
- Engaging in behavior that breaches trust such as withholding information about the case history or asking us to alter our data or diagnosis.

If you terminate therapy, for any reason, you must give 2 sessions written notice in order for the therapist to wrap up therapy and complete the final counseling with you. You will be billed for the cost of the last 2 sessions if you choose to not give notice or choose not to attend those 2 sessions.

### **FEES/POLICIES**

Our fees and policies are applied consistently for all clients. Our office staff and Speech Pathologists do not make our policies or set our fees and they are unable to waive or change them. Please do not ask them to make

exceptions for your family. Our Director will discuss your concerns with you, if your request but consistently applies the policies and fees as well. We regret any inconvenience. Please see our Fee schedule for details. Our fees are subject to change without notice. Any client may leave services if at any time, with notice, if they do not wish to comply with these policies.

## OFFICE AND FINANCIAL POLICIES

The undersigned agrees, whether signing as an agent of, or a patient that in consideration of the services to be rendered to the patient, he/she hereby individually obligates him/herself to pay the account of Professional Speech Services in accordance with its regular rates and terms. Charges are due and payable in full upon billing. In the event that legal action becomes necessary to collect, the undersigned agrees to pay the costs of collection, including attorney fees.

Professional Speech Services is a professional business providing health related diagnostic and therapeutic services to its patients and clients. Professional relationships require honest financial accountability. This document outlines our office policies by which our practice operates and holds itself and its patients and clients accountable.

### CHARGES FOR PROFESSIONAL SERVICES

Every professional service and associated expense rendered will be charged to the patient according to a fee schedule, equally charged to each and every patient with no exception as regulated by CMS Billing Guidelines. In compliance with these CMS Billing Guidelines, no fee or charge can be reduced or waived.

All co-payments, deductibles and outstanding balances will be required to be paid at the time of check in.

Non-urgent professional services may be delayed or terminated within the guidelines of good medical practice for bad faith patient noncompliance with this financial policy.

### PAYMENT

Our office accepts the following terms of payment: Cash, check (a \$35.00 NSF Fee will apply to any returned checks). Our terms of payment once a patient statement has been sent is **NET 30 DAYS**. If unpaid after 30 days a late fee of \$25.00 will be charged monthly for 3 months. If unpaid after 3 months, the account will be turned over to a collection agency.

### INSURANCE

All patients are advised to check with their insurance carrier to check for “in network” and “out of network” benefits.

#### Payment is required as follows:

**Self-Pay** – 100% due at the time of service with a 10% discount.

**Medicare** – 20% of the Medicare and any patient deductible will be collected at the time of service.

**Commercial** – Any patient responsibility discovered at insurance verification process will be collected at time of service. Also patient agrees to pay any amount not paid by insurance for any reason after 60 days from submission. You will be sent a statement notifying you of any unpaid balance.

It is our policy to extend a 60 day credit to patients with valid insurance policies. After 60 days this credit is revoked and all payment will be immediately due.

### COLLECTION AGENCIES

It is our office's policy to use all reasonable means to collect owed funds. Defaults in payment of agreed amounts will automatically be referred to a collection agency for payment. This could also result in dismissal from practice.

**RESPONSIBILITIES OF PATIENT:**

- Patient is responsible for keeping all booked appointments. The patient will be charged \$15.00 per missed appointment without 24 hour advance cancellation notice.
- Patient is responsible for obtaining pre-authorizations and referrals needed for care prior to office visit.
- At each visit the patient is to provide a copy of all valid insurance cards, current mailing address, and telephone numbers.
- Prior to each visit all co-payments, deductibles, and outstanding balances must be paid in full.

**Attendance and Cancellations:** I understand I need to keep a 90% attendance policy in order to maintain my recurring time slot. I understand that I am required to provide at **least 24 hours advance notice** if unable to keep a scheduled appointment because the scheduled time slot has been reserved exclusively for me and/or my family members. I am financially responsible for the reserved appointment. If I cannot keep my appointment I will be charged a fee if proper notice is not given. PROFESSIONAL SPEECH SERVICES may make exceptions and waive the fee, at its discretion, for emergency or unusual circumstances. I understand that insurance companies do not provide reimbursement for cancelled sessions. **Repeated missed appointments may result in termination of therapy and/or change in recurrence of appointment time. Notify us of cancellations by calling 507-434-9177.**

\_\_\_\_\_ **Referrals and Authorizations:** I understand that I am responsible to obtain all referrals from my Primary Care Physician (PCP) and keep track of how many visits were issued and when they expire. If authorization for office visits is required. I need to keep track of how many visits were issued and when they expire. Any services received without a referral or proper authorization will be my responsibility.

\_\_\_\_\_ **Returned Check Fee:** I, the undersigned, agree to pay a fee for any check returned by my financial institution regardless of reason.

\_\_\_\_\_ **Authorization to Release Information:** I HEREBY AUTHORIZE PROFESSIONAL SPEECH SERVICES to release medical information acquired in the course of my evaluation and/or treatment, to my insurance company, other physicians required to participate in my care, or to my child's school district.

\_\_\_\_\_ I have verified that my insurance MAY pay for the speech evaluation/speech therapy. I therefore authorize Professional Speech Services to bill my insurance company. I understand that I am ultimately responsible for payment of services rendered by Professional Speech Services which my insurance does not pay. I further understand that any charges which are delinquent by more than 60 days may be sent to collection attorneys employed by Professional Speech Services.

**Consent for evaluation and treatment:** I consent to and authorize such evaluation and treatment as may be deemed necessary and as prescribed by my physician. I understand that such evaluation and treatment may involve risks of injury and I acknowledge that no guarantees have been made to anyone as to the results of such services, procedures or treatment. I understand that I have the right to consent or refuse consent to any treatment or procedures.

I understand that my therapist will explain the plan of care, including any procedures and treatment that I will undergo. I also understand that my full cooperation with the evaluation process is necessary.

**Personal Valuables:** Professional Speech Services shall have no liability for the loss or damage of money or other valuables while in the clinic for rehabilitation services.

I have read this form, I understand its content and significance and my questions have been answered.

\_\_\_\_\_

Patient or Responsible Party

\_\_\_\_\_

Date

\_\_\_\_\_

Witness

\_\_\_\_\_

Date

If the patient is unable to sign, or is a minor, complete the following: Patient is a minor \_\_\_\_\_ years of age,  
and/or is unable to sign because: \_\_\_\_\_

Your relationship to the patient: \_\_\_\_\_