HORN AND ASSOCIATES IN REHABILITATION, PLLC

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Thank you for choosing us for your speech/language, occupational, physical and/or psychological needs. We are committed to providing you with quality and affordable services. Our office policies are outlined below. Please read, ask us any questions and sign in the space provided. A copy will be provided to you upon request.

FINANCIAL POLICY
We are happy to file your insurance but we want you to remember that professional services are rendered and charged to you or the patient and not to the insurance company.

Proof of Insurance: All patients must complete our patient information form before seeing the provider. We must obtain a copy of your driver's license, or a form of government issued photographic identification, as well as current valid proof of insurance. You are responsible to know your benefits. We will collect estimated out of pocket fees on the day of therapy, which includes deductible, copays and/or coinsurance. Our office accepts cash, checks, MasterCard, Visa and Discover Families are responsible for keeping track of the number of visits, or when and what type of authorization/precertification is necessary. The number of visits and payment of all claims is your responsibility, although we do try to track them as well. Please remember that precertification and/or authorization is no guarantee of payment from your insurance company.

Insurance payments are ordinarily received within 30 days from the time of filing. If your insurance company has not made payment within 45 days, we will ask that you contact your insurance company to make sure payment is expected. We are happy to help you with additional information your insurance company may need to assist in claim payment; however, our office will not enter into a dispute with your insurance company over a claim. If there is no insurance payment activity after 60 days, we will ask for your payment and, of course, reimburse you if your insurance company later pays.

Additional documentation (i.e., disability reports/questionnaires, school updates, school conferences, 504 plans, etc.) and extended phone conversations will be provided based on a time fee and will be the responsibility of the patient.

ATTENDANCE AND CANCELATION POLICY
Consistency in attendance to therapy is essential to making and maintaining progress.

Cancelation/Service Fees: We realize there may be circumstances that require you to cancel your appointment. When these situations occur, **please notify the therapy office at least 24 hour prior to your scheduled appointment**. With this notice, we may be better able to reschedule your therapy time and/or accommodate others waiting for therapy. **Cancelation without 24 hour notice will be assessed a $36.00 cancelation fee**. If you cancel more than one therapy session with different therapists within the same day and without 24 hour notice, this $36.00 fee will be assessed for each session missed. We understand emergencies do arise; in these situations notifications are still expected. Emergency situations will be taken into consideration when assessing the cancellation fee.

Attendance: Regular attendance is expected for therapy. If your attendance falls below 75%, you may lose your regularly scheduled therapy time. If you miss more than 3 sessions without 24 hour notice, you may be discharged from therapy services.

Timeliness: If you arrive late for your session, the session may be cancelled. Many sessions are scheduled for 30 minutes; if you are 10 minutes late to a session, valuable time is lost and we are often unable to accommodate.

Sick Policy: Please respect the health and wellness of all our clients, staff and therapists. We expect you to be fever free and symptom free from illness for at least 24 hours in order to attend therapy sessions.

I understand that I am responsible for any charges not paid by my insurance coverage and I accept responsibility for any collection costs, attorney fees, and any other cost incurred that may result from nonpayment. I understand the above terms and conditions and I authorize my insurance company to pay my claims directly to Horn and Associates in Rehabilitation, PLLC.

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Patient or Guardian (if minor) Signature **Date**

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Printed Name – Patient or Guardian (if minor)