HEARTLAND
Speech & Occupational Therapy
SERVICES, P.C.

Welcome to Heartland Speech & OT!

We realize that you have a choice for your child's therapy services and we thank you for allowing us to be a part of your child's care! We strive to provide outstanding pediatric speech and occupational therapy services in a family friendly setting. Your child will be in good hands with our licensed speech and/or occupational therapists.

Privacy policies statement/HIPAA: You will have an opportunity to review our privacy policies statement at your request. This statement will outline our policies that protect your privacy. We will release your personal health information for billing purposes to be reimbursed for services rendered. You may request (in writing) to prevent us from doing so without penalty or cessation of your care. If you exercise this right, you will be responsible for the cost of your therapy, and it will be your responsibility to submit claims to your insurance carrier for reimbursement of those costs.

I would like a copy of the HIPAA policy: _____YES _____NO Initial here: _____

Appointments: Research has shown that patient/family compliance can greatly affect therapy outcomes. Compliance with your scheduled appointments and home program will increase the success your child has in therapy. We realize that unexpected situations occur and understand with children it is not always feasible to give 24 hour notice for cancellations. We ask that you be respectful of our time and give us as much notice as possible so that we may try to schedule another child that needs to be seen in that time. If you miss 3 appointments without notice, your child's care may be terminated at the clinic's discretion. We typically schedule recurring weekly appointments and require families to maintain 75% attendance. Should this become an issue, it will be discussed and future therapy services may be cancelled.

I have read and understand the appointment/attendance policy: Initial here: _____

Responsible party: The parent/legal guardian that brings the child into our clinic will be considered the responsible party for billing purposes. If the parents are divorced or custody has been transferred to a legal guardian, the custodial parent/legal guardian who brings the child in will be responsible for the bill. It is then the obligation of that parent, not our office, to collect medical bills from the other parent. We do not get involved in billing disputes in cases involving divorce or separation and will not split bills among family members.

Insurance: After filing your insurance, we will wait 60 days for a response. If we have no response from your insurance company, you will be responsible for the unpaid balance. You will then have 30 days after the receipt of your first statement to make the minimum monthly payment. We are a Preferred Provider for Blue Cross Blue Shield, UHC, Midland's Choice, and Aetna. We also accept the United Healthcare Community Plan for Nebraska Medicaid.

Billing: Statements are sent out at the end of every month and the balance is due by the 15th of the following month. We accept check, cash, and credit card.

Payment Plan/Minimum Payment: If you are unable to pay your account in full, you may contact our clinic to discuss a payment plan. A payment plan means you will set up an automatic payment of an agreed upon amount to be paid with a credit/debit card monthly. A minimum payment of $50 or 20% of the outstanding balance (whichever is greater) is required on any outstanding balance.

Past Due Balance: If your balance is over 60 days, you will receive a note on your statement regarding your past due balance. We ask that you call our clinic within 15 days to pay the balance or set up an agreed upon payment plan. If you do not contact our clinic within 10 days after the final notice, your account will be turned over to a collection agency after adding a finance charge. Once this happens, it is in their hands and we will not take the account out of collections. All questions or payments should be sent to them. At that point, we reserve the right to terminate you from our practice.

Authorization: I have read and agree to the terms and conditions listed above. I understand that I am financially responsible for charges not covered or denied by my insurance company. I further agree to pay the cost of collections, court costs, and other reasonable fees should they be required in the event of my nonpayment.

Patient Name:	Date of birth:
Parent/Guardian Name:	Parent/Guardian Signature: Date: