Bliss Speech and Hearing Services, Inc.
12700 Hillcrest Road, Suite 207 · Dallas, TX 75230-2068
Phone: (972) 387-2824 • FAX: (972) 387-9097 • www.blissspeech.com

PAYORS RESPONSIBILITY

Thank you for choosing Bliss Speech and Hearing Services, Inc. as your health care provider. We are committed to the success of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any intervention.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, or VISA/MASTERCARD.

Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to contract. Therefore, all payments are due in full at the time of your visit. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable, customary and/or medically necessary under your medical insurance plan. **We are 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 patient by BLISS SPEECH AND HEARING SERVICES, INC. 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.

The undersigned does hereby further acknowledge that he/she shall be fully responsible for the payment to the provider, BLISS SPEECH AND HEARING SERVICES, INC., of the amount BLISS SPEECH AND HEARING SERVICES, INC. bills for any services that are identified as Non-Covered Services by the undersigned's insurance company.

Notwithstanding anything contained hereinabove to the contrary, should the undersigned be covered by a Preferred Provider Plan (PPO) for which we are a provider, and said plan calls for CO-PAY, the insured will pay, in full, all invoices at the time of **each visit** until such time as the services provided by BLISS SPEECH AND HEARING SERVICES, INC. within fifteen days of said determination. Once the patient has been approved under the PPO plan, all co-pays and deductibles will be due to prior to the treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

Change in Insurance Plan

Should your insurance change for any reason, you are responsible for notifying us in writing. Failure to notify us in writing will cause you to be responsible for any losses incurred by Bliss Speech and Hearing Services, Inc. due to said failure.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination is usual and customary rates.

Adult Patients

Adult patients are responsible for full payment at time of service.

Minor Patients

The parent (or guardians of the minor) or the adult accompanying a minor is responsible for **full** payment. For unaccompanied minors, treatment will be denied unless charges have been preauthorized to an approved credit plan, Visa/ MasterCard, or payment by cash or check at time of service has been verified.

Missed appointments

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Other billing items

Periodically**,** school visits, parent conferences, and various off-site visits will be scheduled in an effort to develop a more comprehensive therapy plan. The hourly rate will be billed for these meetings, to include transportation to and from the off-site visit. Requested or necessary reports are billed at the regular hourly rate.

Release of information

See the accompanying Notice of Privacy Practices for policies pertaining to Protect Health Information (PHI).

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy:

x_____ Date_____
Signature of Patient or Responsible Party

x_____ Date_____
Signature of Co-Responsible Party