phone: 586-307-4757
fax: 855-393-6740
email: office@nhspeech.com
web: www.nhspeech.com

FINANCIAL RESPONSIBILITY AGREEMENT

Please initial the **applicable** statements:

_____ Insurance may or may not cover the cost of services rendered. I understand that I am responsible for all charges not covered by insurance including copays and coinsurance. **Payment is due at the time of service**. Payment can be made by cash, check, credit/debit card, or PayPal.

_____ I authorize New Heights Speech and Language, PLLC to submit insurance claims on my behalf.

For out-of-network patients:
_____ I understand the New Heights is an **out-of-network provider**. I understand that I am subject to the **out-of-network** terms of my insurance plan.

RATES:

Speech and Language Evaluation	$400
Consultation (including IEP)	$105 per hour
Individual speech and Language treatment	$150 per session
Feeding and Swallowing Treatment	$200 per session
AAC Treatment and Programming	$200 per session

Patient Name Date of Birth

Responsible Party (PRINT) Relationship to Patient

Signature of Responsible Party Date