PARENT/CLIENT CONTRACT FOR INDIVIDUAL SPEECH THERAPY

Thank you for selecting Communication Station as your provider for Speech Therapy services. We are dedicated to helping the voices of the children in the Hudson Valley be heard. This contract identifies the financial expectations of the client for services to be provided.

Communication Station and ____ hereby agree to the terms set forth below:

Notification of Legal and Privacy Policies:

- Speech therapy services are provided in the offices of Communication Station's therapy room by a New York State licensed and ASHA-certified (Certificate of Clinical Competence) speech-language pathologist.
- Communication Station will not be held responsible for any claims or damages of any kind, for injury to any person or persons, and/or for any damages due to loss of property arising directly or indirectly out of participation in these therapy sessions.
- All client information will be kept confidential. It will be kept in a secure location away from public access.
- Evaluation reports, progress reports, therapy goals and therapy plans will be sent to outside sources (i.e. doctor's office, insurance providers) in a private manner, if applicable.
- Written approval will be obtained to share private information with other outside sources or professionals.
- This is the entire agreement and no promises outside of the agreement made on or before the effective date will be binding upon the parties.

Cancellations

- If your child is sick or an emergency occurs, please contact Communication Station as we are understanding of unexpected situations.
- If we are unable to keep a therapy appointment for any reason, we will notify you as soon as possible, and a makeup appointment will be scheduled.

Sessions

- Communication Station can provide an initial evaluation at the request of the client/client's parents; however, we are not required to conduct our own independent evaluation to establish a plan of therapy in order to bill for our services. Parents can provide their child's school, hospital, and/or previous private practice evaluation report as a means of generating to obtain an updated account of the client's ability level. An updated evaluation may be needed to establish goals and provide therapy.

- Speech-Language therapy services will be provided based on goals agreed upon by both parties in order to best serve your individual child. Goals can be established through one of more of the following means: administered evaluations/reports, outside evaluations/reports, observations, and parent requests.
- In order to ensure the safety of your child during his/her therapy session, it is important that an adult/guardian be present at the Communication Station office during therapy. Parents are welcome to observe therapy sessions through the window of the therapy room doors.
- Therapy sessions will be 30 or 45 minutes. Sessions length will be tailored towards what would best serve the needs of your individual child.

Financial Policy

- Rate of expressive and receptive language with an articulation evaluation, including report: $275.00
- Rate of expressive and receptive language evaluation, including report: $250.00
- Rate of articulation evaluation, including report: $225.00
- Rate of feeding evaluation, including report: $225.00
- Rate of speech-language therapy 30 minutes individual sessions: $55.00 or group sessions: $25.00
- Payment is expected at the time of service unless prior arrangements have been made.
- Accepted forms of payment include: credit card or checks made out to Communication Station.
- A $25 fee will be applied to all bounced checks.
- A credit card number must be kept on file in case payment has not been received at the time of service. All credit card payments will be charged within 24 hours.
- The client is solely responsible for submitting all claims to their insurance company, should one wish to receive reimbursement for any services rendered by Communication Station.
- Communication Station does not participate with any insurance companies but will provide a receipt with diagnostic and treatment codes within two weeks of received payment where services were rendered.
- The rates of evaluation and/or therapy are subject to change.

Cancellation Policy

- We schedule our appointments so that each child receives the right amount of time to be seen by our speech-language pathologists. That’s why it is very important that you keep your scheduled appointment with us and arrive on time.
- If you do not cancel or reschedule your appointment within 2 hours of your scheduled appointment, we will assess a $25.00 “no-show” service charge to your credit card account. This “no-show charge” is not reimbursable by your insurance company. You will be charged directly for it using the credit card number on file. After three consecutive no-shows to your appointment, Communication Station may decide to terminate its relationship with you.

- I understand the “no-show” policy of Communication Station and agree to provide a credit card number, which will be charged $25.00 for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment within 2 hours in advance in order to avoid a potential no-show charge to the credit card provided.

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Parent Signature

I read, understand, and agree to the policies outlined above. This is the agreement in its entirety, an no promises outside of the agreement made on or before the effective date will be binding upon the parties. My signature indicates that I consent to all rules and regulation of Communication Station.

Client (Child) Name: ____

Parent Signature: ____ Date: ______________

Email Address: ____

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other ___________________________________
Cardholder Name (as shown on card): ___________________________________
Card Number: ___________________________________
Expiration Date (mm/yy): __________________________ CVV Code: __________________________
Cardholder ZIP Code (from credit card billing address): ___________________________________

I,____, authorize Communication Station to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Customer Signature ______________________________________ Date ____________________________________