FSU | L.L. SCHENDEL SPEECH & HEARING CLINIC
COMMUNICATION SCIENCE & DISORDERS

FSU SPEECH & HEARING CLINIC FINANCIAL POLICY

Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, sign in at the front desk and present your current insurance card. This is your verification of the correct
   Insurance and consent to bill them on your behalf.
   a. If we do not participate in your insurance plan, **payment in full is expected from you at the time of your office visit.** We are happy to provide you with a receipt so that you may file for reimbursement from your insurance company.
   b. **Co-Payments are due at time of service.** You are responsible for any/all co-payments, deductibles, and co-insurances.
   c. ***We accept several health insurance plans and some Medicaid HMOs***. Please check with our front office staff **before your appointment** to determine whether your health insurance plan is one that is accepted by our clinic, and any documentation that will be needed for your appointment (e.g., an order from your physician).
   d. If the insurance company that you designate is incorrect, **you will be responsible for payment of the visit** and for submitting the charges to your correct insurance plan.
2. It is your responsibility to understand your benefit plan. It is your responsibility to know:
   - if a written referral or prior authorization is required to see a speech pathologist or audiologist,
   - if preauthorization is required prior to you/your family member receiving services, and
   - What services are covered by your insurance? Not all services we offer are covered by all insurances.
3. We do not submit to secondary insurance plans. If you have secondary insurance, we will provide you with a receipt to submit for reimbursement. Your secondary insurance will send the reimbursement check directly to you.
4. After your insurance has paid, **you are responsible for any balance on your account.**
5. **Payment for an office visit is to be paid at the time of the visit.**
   - Any outstanding account balance greater than 30 days will be charged a $5 re-bill fee every 30 days unless other arrangements have been made previously***. Unpaid balances exceeding 90 days with no effort to make payment will result in dismissal from the clinic's caseload.***
6. If you do not have insurance or we do not accept your insurance plan, and if you find that our regular fees would cause a financial hardship, please ask for an Adjusted Rate Application. **You must submit all requested documentation to be considered for an adjusted rate, and submitting an application does not guarantee that you will be approved.**

I HAVE READ AND UNDERSTAND THIS POLICY, AGREE TO COMPLY, AND ACCEPT THE RESPONSIBILITY FOR ANY PAYMENT THAT BECOMES DUE AS OUTLINED IN THIS DOCUMENT.

SEMESTER: _____ **Charge Per Session:** _____ **Your initials:** _____

Client Name (PRINTED): _____

Signature (Responsible party): _____

_____ _____ _____
Responsible party member's name Relationship Date

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