GARRISON CITY
speech & language services

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Financial Policy

Please Read, Sign and Initial Before Your First Appointment

Garrison City Speech & Language Services (GCS&LS) is a participating provider for **Aetna, Allways Health, Ambetter, Anthem Blue Cross/Blue Shield, Cigna, Harvard Pilgrim Healthcare, Health Plans, Inc., MaineCare, Martin's Point Health Care, Medicare, NH Healthy Families, NH Medicaid, Tricare East, Tufts Health Plan, United Healthcare and Well Sense**. Patients with these insurance plans will be required to pay the deductible, co-payments, co-insurance and non-covered services (i.e., evaluation reports, meetings).

Please provide credit card information to be maintained on file:

Your account will be automatically charged on the date of service for co-payments, co-insurance and deductibles. Your account will be charged within 5 days of receiving adjudication from your insurance for the patient balance due if there is one._____ (please initial)

Credit Card # _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ **Exp Date:** _____/_____

Name on Card: _____ ___ _____ **3-digit CVV#** ___ ___ ___
First **MI** **Last**

Billing Zip Code: _____

For non-participating insurance plans or for patients without insurance benefits, payment is due in full on the day of service. A detailed receipt will be provided to those with non-participating insurance plans to submit for coverage of out-of-network benefits. _____(please initial)

Professional services are rendered and billed to the patient, **NOT the insurance company**. GCS&LS will bill the above listed insurance companies directly as a courtesy to you. GCS&LS is not employed by the insurance company. If for **any reason** the insurance company denies payment, you are **responsible for the total amount billed to you within 30 days** of the invoice date. _____(please initial)

Patients/legal guardians are responsible for knowing their insurance benefits. Please be sure to review your insurance booklet and policy **AND** contact your insurance company's Benefits and Eligibility Department to determine if services are covered and what is required before the initiation of services. _____(please initial)

By signing below, you agree to the above financial policy and understand that if your account becomes delinquent, you will be responsible for collection agency fees and/or attorney/court fees. There will be a $35.00 charge for returned checks and either a $25.00 or 50% service charge per month (whichever is less) for invoices not paid within 30 days of the invoice date. GCS&LS accepts cash, checks, money orders or major credit cards as payment._____(please initial)

Print Patient's Name:_____

Patient's Signature:_____ **Date:** _____
(Parent/Guardian Signature if patient is under 18)