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Speech-Language Development, SLP P.C.

Lyudmila Kimyagarova
Director

MACCC/TSHH P.R.O.M.P.T. trained-Level II
Speech-Language Pathologist
NYC License # 014994

ASSIGNMENT OF BENEFIT FORM

Patient's name:_____Date:_____

I _____understand that my insurance company will be sent an itemized bill for each session in accordance to reasonable and customary charges. I agree to assign benefits directly to **Speech-Language Development, SLP P.C.** for all therapy services rendered. I also agree to remit any monies sent to me in error from my insurance company for services rendered to (patient's name) _____. I agree to pay for all services rendered should my insurance company deny payment for services rendered, and will be responsible for any deductible, co-insurance or co-payment, to be at the time of my visit.

For patients who pay privately or have out-of-network benefits, payments are due at the time of your visit. The fee for service for an initial evaluation is_____. The fee for service for all follow-up visits is_____. If requested, Lyudmila Kimyagarova will assist you in submitting claims to your insurance company.

CANCELLATION AND DISCONTINUANCE FROM SERVICES POLICY

This office required 24 hours notice for cancellations. Otherwise, you will be charged the full fee of the session. In addition, you will be charged the full fee for the session if you do not show for a confirmed appointment. Should you miss three consecutive visits it will be considered that you are not in adherence or compliance with your plan of care, and will be discharged from this office. Your primary physician will be notified and you will be given the names of three like professionals for your future use should you decide to begin therapy services again.

I have read and agreed to the above policies and procedures.

Patient or Responsible Party Signature_____Date_____