



Payment Agreement & Consent to Evaluate/Treat

I consent for Saren Schapiro, M.Sc., CCC-SLP to provide my child _____ with Speech-Language Therapy services, including assessment and intervention services. I agree to remit payment according to the fee schedule outlined below.

Official Fee Schedule: All patients will be provided a monthly invoice by mail and/or email, depending on the agreed upon format. Payment is due in full within 15 days of invoice date in the form of cash or a personal check. A credit card will be kept on file and charged for your invoice amount if payment is not received within 15 days of invoice date. You will be notified 24 hours in advance if your credit card will be charged.

We are now able to provide clients with insurance billing services. Upon receipt of payment for services, we will then submit the claims to your insurance company, follow up on claim status, and reimburse you the amount your insurance plan covers.

Service	Fee
Speech-Language Therapy	\$150 per hour *60 minute sessions include 50-55 minutes of therapy, and 5-10 minutes of parent contact/education (email, phone, or in person) *45 minute sessions include 40 minutes of therapy and 5 minutes of parents contact/education (email, phone, or in person)
Oral Motor & Articulation Assessment	\$250 (1 hour evaluation and comprehensive report)
Language and/or Language Processing Assessment	\$350 (2 hour evaluation and comprehensive report)
Articulation & Language Assessment	\$450 (up to 3 hours of evaluation and comprehensive report)
Professional Letter (to doctors, school, insurance companies, etc)	\$40
Parent-Clinician Meeting or Phone or In Person Conference	\$120 per hour (the first 15 minutes of phone conferences are free)
Conference with other Medical or Therapeutic service providers, or IEP meeting	\$120 per hour

*Returned checks are subject to a \$35 fee.

*Unpaid balances are subject to 1.5% interest.

CREDIT CARD INFORMATION (must be on file, even if electing to pay by check)

Credit Card Number: (Visa, MC) _____

Name on Card: _____

Expiration Date: _____

Full Billing Address: _____

Card Verification #/ Security Code: _____

*I understand that including my credit card information above allows By Word of Mouth to run my credit card and input an online signature in lieu of my signing the credit card receipt:

____YES (please mark 'x' in the line)

I agree to the fee schedule as outlined above for my child's Speech-Language Therapy services. I agree to allow 'By Word of Mouth' Speech Pathology Services to charge my credit card as outlined above.

Parent/Legal Guardian

Date

Therapist/Witness

Date



Release of Medical Information

I authorize Saren Schapiro to release necessary and pertinent medical information to physicians, case managers, teachers, other therapists, and insurance companies as needed for my child, _____. I authorize Saren Schapiro to obtain medical and pertinent medical information from the patient's physician, therapists, teachers, other therapists, case managers and insurance companies as needed.

Parent/Legal Guardian

Date

Therapist/Witness

Date