Mary Barry and Associates, LLC
Speech and Language Pathologists
Office and Financial Policies

Welcome and thank you for choosing Mary Barry and Associates, LLC. We are committed to providing you with the highest quality care, in an efficient, timely and cost-effective manner. We hope that by providing you with our policies in advance, we can prevent any misunderstanding or frustration at the time of your visit.

Initial____ **Insurance:** When making an appointment with one of our speech language pathologists, it is your responsibility to confirm with our office and your insurance company that the therapist is currently under contract with your plan. As a service to you, we will bill in-network primary insurance companies. While providing this service, it is extremely difficult for us, and our therapists to be aware of the multitude of individual requirements for each of these plans. Each plan has its own stipulations regarding the coverage of, and payment for services; therefore, **it is your responsibility to know your plan's benefit policies including co-payments, prior to your appointment.** If your plan requires that you have a referral prior to seeing a specialist, please contact your primary care physician so that you will have the referral in hand at the time of your appointment. In order for us to bill your insurance, we must have a current copy of your medical card along with all required information. If this is not provided, at the time of appointment, you can reschedule, or pay in full at the time of service. We allow 30 days for your insurance to respond on a claim, and 60 days for them to process and/or issue payment. If your insurance does not respond or pay your claim within 60 days, the full balance will become the patient/guarantor's responsibility.

Initial___ **Co-payments:** Copayments are due at the time of check-in. It is your responsibility to know if you have a co-pay with your insurance. If the co-pay is not paid at the time of service, a $10.00 service charge will be assessed each time.

Initial:___ **Co-insurance:** Coinsurance is due upon receipt of an invoice from Mary Barry and Associates, LLC. An interest rate of eighteen (18) percent per annum will be charged to your account for all past due amounts

Initial___ **Check-In:** We do our best to keep on schedule, so please arrive for your appointment on time. On follow up visits, you will be asked to sign-in and verify demographic and insurance information so that our records remain up-to-date.

Initial___ **Check Out:** Please be prepared to pay any past balances on your account. Payment of co-pays and non-covered services will be required at the time of service. We accept cash or check.

Initial___ **Out-of Network:** If your insurance is out-of-network, an insurance that Mary Barry and Associates, LLC does not contract with, **you must pay for your services at the time of service.**

Initial__ **Medical Necessity:** I understand that I am responsible for all charges incurred. If my insurance policy determines/denies my procedure as **NOT MEDICALLY NECESSARY,** I am responsible for payment in full.

Initial___ **No Shows and Late Cancellations:** we require a 48-hour advance notice if you must cancel your appointment. **Each patient is allowed one NO SHOW without penalty.** The second NO SHOW will result in a full charge to your account with 100% payable by you, not the insurance company.

I have read, understand and agree to the above office and financial policies. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information necessary for insurance filing and pre-certification by signing this statement.

X_____ DOB_____
Patient Name

X_____ Date_____
Signature of Patient or responsible party