



## **Office Policies**

### **Allergies**

Our office is **NOT an allergy free** environment. Various foods and odors are present throughout the office for therapy purposes. It is the patient or guardian/parent's responsibility to inform the office manager of any allergies in writing to further discuss possible accommodations. We do not guarantee an allergen free environment.

### **Sickness**

Appointments should be cancelled due to illness. *Patients must be without fever for 24 hours without medication* to attend therapy in this office. We ask that you notify our office as soon as possible of any illnesses for scheduling purposes.

### **Cancellations**

We will strictly enforce the cancellation policy. Failure to give a minimum notice of **24 hours** for missing your appointment will result in a **\$25.00** charge on your account, which must be paid before the next session. This fee cannot be billed to your insurance.

### **Late/No show**

**Appointments will begin and end** on time despite patient's late arrival or other patient circumstances. If you are more than 15 minutes late for an appointment, the appointment will be considered a "no show", and our office will charge a \$25 missed appointment fee. This fee can not be billed to your insurance.

### **Extended Absences**

Our office will hold appointment times for up to two weeks. For absences greater than two weeks, our office will schedule based on what appointments are available upon your return. If you would like to hold your appointment time for greater than two weeks, please see the office manager for accommodations.

### **Reports**

All requests for reports, documentation, or paperwork from Dr. Park require 4-6 weeks from the date of the request, which must be submitted in writing by the parent, guardian, or patient who is making the request.

**Forms**

Any forms, letters, notes, or outside paperwork will be completed at the discretion of our office. There will be a **\$25 fee per form or letter**. There will also be a 10 business day turnaround time for each form or letter. This fee cannot be billed to your insurance.

**Coordination with other therapists**

It is our goal to help your child achieve their potential and maximize their progress. Our office ***does not share treatment plans or goals with other private speech therapy offices.*** We are happy to coordinate with ABA, OT, and PT when this coordination is necessary to achieve therapy goals.

**IEP & School Speech Therapy Consultation**

There is a charge of \$300 per hour, charged in 15 minute increments, for any school speech therapy consultations. The minimum charge is \$75. This fee cannot be billed to your insurance.

**Payment summaries or other paperwork**

Any account summaries or multiple payment receipts requested will be completed within ten business days. *Requests to expedite summaries will result in a fee of \$25 that cannot be billed to your insurance.*

**Parent Education**

Please be advised that this office is obligated to bill separately for any time spent discussing patient care outside of the routine follow-up to that day’s session. For any additional time spent in discussion regarding the patient, our office will bill your insurance company for parent education, home care, or consultation for that date. This could result in a change to your normal fee for that date. You will be liable for any additional fees your insurance company determines is your responsibility.

**Late payment**

All payments are due at time of service. *Our office will charge a \$5 fee for each late payment.* This applies to co-pays, co-insurance, deductible fees, and out of pocket fees. For services denied by insurance after a claim has been submitted, payment is due at the time of notification of the denial. **Three missed or late payments will result in removal of the patient from our schedule.**

**I acknowledge and agree to all of the outlined office policies outlined above.**

Patient name: \_\_\_\_\_ Patient date of birth: \_\_\_\_\_

Printed name of parent or guardian: \_\_\_\_\_

Signature of patient, guardian, or parent: \_\_\_\_\_

Date: \_\_\_\_\_