Bloom Speech Therapy
3370 Brae Bourn Drive,
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215-870-9768

Payment Policy & Fee Schedule

Thank you for choosing our private practice to serve you. We are committed to providing you with the highest quality care. Please know that the timely payment of your bill is an integral part of our service and as such, this payment policy is an agreement between you and Bloom Speech Therapy for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family member. As a client of Bloom Speech Therapy you are required to carefully review and sign our payment policy.

Fee Schedule

(Effective 9/1/2021)

Service #1	**Evaluation**	**$300 per evaluation**
Service #2	**60 Therapy**	**$120 per 60 minutes**
Service #3	**45 Therapy**	**$100 per 45 Minutes**
Service #4	**30 Therapy**	**$75 per 30 Minutes**

Please read the following information carefully:

All therapy fees (including session fees and/or co-pays, if applicable) are due:

☐ Within 48 hours of time of service

We accept the following payment methods at this time: credit card, check, cash

Name of Client: _____ Date of Birth: _____

Please read and check all boxes to acknowledge understanding and the sign below:

□ I understand that I am responsible for all costs / fees that any third-party payer (ex. insurance company, private school, etc.) does not cover. In the event that a third-party payer source determines that rendered therapy services are “not covered” or otherwise denied, I will be responsible for all outstanding charges. I understand that I will be billed accordingly and will be responsible for immediate payment. I also understand that Bloom Speech Therapy will not become involved in disputes between you and your third-party source regarding uncovered charges or reasons for denial.

□ I understand that if fees are not paid in full, treatment sessions may be postponed or cancelled until payment is received.

□ I understand that all returned checks will be subject to a **$ 20** returned check fee. Charges incurred and not paid after **30 days** may be turned over to a collection agency at the client’s expense. Overdue accounts may also be reported to a Credit Bureau.

□ I understand that I am responsible for all legal and collection fees, which Bloom Speech Therapy may incur if payment is not made in accordance with the terms and conditions herein.

□ I understand that refunds will be issued only in instances of overpayment. All refunds will be processed within **14 days** after the overpayment is discovered on the client’s bill or at the time the refund is requested. Refunds for payments made with a credit card will be credited back to the credit card used, all other refunds will be issued by a check. Client’s who used a third-party source will not be issued a refund until full payment is received from the appropriate source.

□ I, understand that all cancellations require **24 hours** notice and that there will be a **$ 50** charge for any cancellations made less than **24** hours. This charge is my sole responsibility and will not be covered by a third-party source.

□ I, _____, (client / guardian name) understand the payment policy and the risks of not adhering to it.

_____ _____
Print Name of Client Date of Birth

_____ _____ _____
Signature of Client, Guardian or Responsible Party Relationship to Client

_____ _____
Private Practitioner / Witness Date