SUPREME SPEECH
THERAPY FOR ADULTS

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Supreme Speech Therapy Consent Form

PLEASE READ CAREFULLY BEFORE SIGNING. YOUR SIGNATURE WILL ACKNOWLEDGE THAT YOU UNDERSTAND ALL OF THE ITEMS MENTIONED BELOW. IF YOU HAVE QUESTIONS REGARDING ANY SECTIONS, PLEASE FEEL FREE TO ASK.

Consent to Therapeutic Services

I consent to the procedures, which may be performed during the duration of this outpatient treatment.
I understand that if I fail to carry out the follow-up care, I do so at my own risk.
I understand that a licensed speech-language pathologist will provide care.

Financial Agreement/Guarantee of Payment and Assignment of Benefits For Medicare Beneficiaries:

I request payment of authorized Medicare benefits be made on my behalf directly to Supreme Speech Therapy for Adults. I authorize Supreme Speech Therapy if it chooses, to pursue on my behalf any appeals of denial of my insurance benefits, and to release my medical records as required to determine benefits payable. Supreme Speech Therapy, it's agents and employees are hereby released from any and all liability of any nature that may arise from the release of information. I understand that all insurance coverage estimates quoted to me and/or other responsible party is estimated, and that I and/or other responsible party shall be liable for all charges not covered by Medicare whether or not such coverage agrees with the amount estimated. I certify that I have disclosed any and all health insurance coverage information. I understand that I am financially responsible for all charges whether or not paid by Medicare.

For all other patients:

I understand that payment is due at the time of treatment. I understand that it is my responsibility to call my insurance company to estimate my reimbursement and completely understand my speech therapy benefits. Additionally, I understand that it is my responsibility to assist Supreme Speech Therapy staff in obtaining any required healthcare referrals when necessary. Furthermore, I understand that it is my responsibility to send the paperwork provided by Supreme Speech Therapy to my insurance carrier for their consideration for reimbursement to me. I understand that Supreme Speech Therapy will provide me with any documentation requested by me and/or my insurance carrier. Lastly, I understand that the amount of reimbursement I will receive will vary according to the terms of my insurance policy. Supreme Speech Therapy will not make a guarantee or estimate regarding what reimbursement my plan allows and I am ultimately responsible for payment for the services provided by Supreme Speech Therapy.

Patient Name _____ Patient Signature_____ Date_____