



South Shore Speech, Language and Swallowing Disorders, PLLC

400 Montauk Highway, Suite 152, Babylon, NY 11702

Phone: 631-669-7098 Fax: 631-669-3736

OFFICE POLICIES

South Shore Speech, Language and Swallowing Disorders, PLLC is committed to providing you with the best possible care and service. Your clear understandings of our Office Policies are important to our professional relationship.

REGISTRATION FORMS: Patients must complete all information/registration forms prior to seeing the speech-language pathologist. A signed, dated prescription is required by NYS law. A copy of your insurance card(s) and photo I.D. will be copied and placed in your chart.

PRESCRIPTIONS: It is **your responsibility** as the patient to have a current prescription on file at all times.

INSURANCE: As a courtesy, we will verify your insurance; however it is your responsibility to know your coverage. If for any reason your insurance company should refuse payment of the bill, you are responsible for payment at the office rate. Should your insurance change, please notify us immediately.

COPAYMENTS: By law we are required to collect our carrier designated co-pay at the time of service. Please be prepared to pay your co-pay at each visit. For your convenience, we accept MasterCard, Visa, debit card, cash or checks.

NON-CO-PAY PLANS: If your plan does not require a co-pay, you will be responsible for any deductible, coinsurance and balance your plan does not cover as indicated on the EOB (Explanation of Benefits).

SELF-PAY: Payment is due at time of treatment. Any unpaid balances are your responsibility.

REFERRALS: If your plan requires a referral from your Primary Care Physician, it is **your responsibility** to obtain it prior to your scheduled appointment. If you do not have a valid and current referral with you or on file, you will be required to reschedule your appointment.

NO SHOW FEE: There will be a **\$25.00 No Show Fee** charged for any appointments that are not cancelled. We ask that you give us the courtesy of a phone call at least 24hr. in advance if you cannot make a previously scheduled appointment.

Please sign below to acknowledge agreement of our policies.

Signature: _____ **Date:** _____