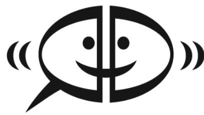

Albuquerque **Speech Language Hearing** Center

Be a part of the conversation.SM

FINANCIAL POLICY

Our mission is to provide our patients with the highest quality care. To better serve you, we accept most insurance and will help you receive the maximum allowable benefits. To do this successfully*, we rely on the information you provide to us at the time of service* and your understanding of this financial policy. **Assisting in the filing of insurance claims is a courtesy we extend to our patients; please let us know in advance if you prefer to file your own insurance claim.**

FINANCIAL RESPONSIBILITY

All co-payments, co-insurance, deductibles, fees, payments, or non-covered services are due at the time of service. **Not all services are covered by all insurance companies -** please refer to your insurance policy to determine your coverage. By signing this document, the patient/parent/legal guardian is accepting financial responsibility for the services rendered, and may be billed the portion not paid by insurance.

REFERRALS

Most insurance companies require referrals for our services. If we do not have the required referral at least **TWO DAYS** in advance of your appointment, we reserve the right to collect payment from you at the time of service. We will send you a refund if we receive payment from your insurance company. If you are not using insurance, a referral is not required.

NETWORKS

It is your responsibility to know if the services we provide are in-network as there are multitudes of plans, and it is impossible for us to ensure we are providers on your specific plan. We must stress that our financial relationship is with you, not with your insurance company.

NON-COVERED SERVICES

Fees for services not covered by your insurance plan will be due at the time of service. We accept cash, checks, MasterCard, Visa, Discover, or debit/check cards with one of the previously listed logos.

RELEASE OF INFORMATION AND BENEFITS

I have read and understand the financial policies of the Albuquerque Speech Language Hearing Center. I request payment of authorized insurance benefits be made on my behalf to ASLHC for services rendered. I authorize release of patient records to physicians upon request, and to my insurance carrier or its agents as required to determine benefits payable for the services rendered.

AUTHORIZATION FOR TREATMENT

I hereby authorize ASLHC to administer and perform diagnostic, therapeutic, or other services, procedures, or treatment as may be necessary for proper care.

____ ________________

Patient/Authorized Signature Relationship Date

Patient Name (Printed):____

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