Suburban Pediatric Speech and Feeding Consulting
Aurora, IL
Office: 630-660-6016
Fax: 630-499-9307

Conditions of Admission

Patient's Name: _____ Date Of Birth: _____

Authorization and Consent for Treatment

I consent to and grant permission to the employees of Suburban Pediatric Speech and Feeding Consulting to render to my child routine clinical care including evaluations, educational services, and therapy activities/procedures during my receipt of services, and to carry out the orders of my child's physician, including consultants, associates and assistants of his/her choice. I also acknowledge that Suburban Pediatric Speech and Feeding Consulting has not made any guarantee or warranty as to the results of any services or treatments given.

_____
Parent/Guardian Initials

Authorization for Release of Information

I hereby authorize Suburban Pediatric Speech and Feeding Consulting to furnish and release medical information to my private insurance carrier, or other third party payer, as may be required for the determination of benefits payable. I grant permission for Suburban Pediatric Speech and Feeding Consulting to communicate all aspects of my child's care with the physician(s) whom I have identified.

_____
Parent/Guardian Initials

Insurance

If I am unable to provide Suburban Pediatric Speech and Feeding Consulting with my current insurance information prior to my child's appointment, I will pay in full for that day's visit. I agree that I am responsible for knowing and understanding my insurance benefits as they relate to therapy services.

I understand that the benefits stated by my insurance company are not a guarantee of payment or coverage, and all insurance payments are subject to medical necessity and eligibility at the time services are rendered. I understand that an office visit and specific therapy charges are incurred at each appointment. I understand that I am fully responsible for all charges for services and/or treatment rendered, and I further agree that all amounts are due upon request and are payable to Suburban Pediatric Speech and Feeding Consulting.

I will provide Suburban Pediatric Speech and Feeding Consulting with a copy of my insurance card each time I receive a new card and/or my insurance information changes. I understand that if my insurance company delays payment or is waiting on additional information from me before they render payment, and the balance is past 60 days, the balance is my responsibility and is due immediately.

All parents are expected to know and understand their coverage and benefits for therapy services. You can verify your benefits by calling the phone number on your insurance card and asking a representative from your insurance company. It is very important that you ask specifically about any "exclusions" or "limitations" to therapy benefits.

Please remember that your insurance policy is between you and your insurance company. A quote of benefits from your insurance company is not a guarantee of payment.

In the event your insurance chooses not to pay for services, you are ultimately responsible for all charges.

_____ _____

Parent/Guardian Initials Date

Valuables

I understand that Suburban Pediatric Speech and Feeding Consulting does not assume responsibility for personal property brought to or left at the facility. I have been advised to leave personal property at home, unless specifically requested by a therapist to assist in my child's treatment.

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Parent/Guardian Initials

Photography/Video Release

I (circle one) do / do not give consent for Suburban Pediatric Speech and Feeding Consulting to take photographs and/or video of my child for clinical, educational, and/or celebratory purposes.

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Parent/Guardian Initials

Cancellation & Late Policy

I understand that a fee of $50.00 will be due upon the next scheduled visit if notice of a cancellation is received less than 24 hours before the scheduled appointment time, or if I fail to show up for any scheduled appointment. I further understand that three consecutive cancellations and/or "no shows" (a missed appointment without communication to our office), or habitual cancellations will result in my child being discharged from therapy.

I understand that if I am consistently late to my child's appointment, a charge of $30.00/15minutes will be due upon each late arrival.

_____
Parent/Guardian Initials

Certification

I certify that any and all information give by me to Suburban Pediatric Speech and Feeding Consulting is correct, to the best of my knowledge. I agree that a copy of this form shall be valid as the original and will not expire. I have read this form (or it has been read to me) and I certify that I understand and agree to all of its conditions.

_____ _____
Parent/Guardian Signature Date

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Relationship to Patient

Illness

I understand that children being seen in home or clinic need to be in good health. My child has to be fever free for at least 24 hours if previously sick. Please notify your therapist so that they are aware, or if there is a highly contagious illness within the family or household.

_____ _____
Parent/Guardian Signature Date

Acknowledgment of Notice of Privacy Practices

A copy of our HIPPA Privacy Policy is provided to you at your child's first evaluation or therapy appointment. Additional copies will be provided upon request.

_____ _____
Parent/Guardian Signature Date