Lauren Hughes, M.S. CCC-SLP
Expressions, Director
(205)-378-9447
director@expressionsccd.com
www.expressionccd.com

Policies and Procedures

Please fill in your child's name in the blank below. Read through the following and initial where indicated, then sign your name at the end of the document.

The following contract represents an agreement between Lauren Hughes, owner and operator of Expressions Center for Communication Disorders, and the parent(s)/guardian(s) of:

_____

Contract and Policies

I am committed to providing you and your family with the best speech and language therapy I can. In order to help me do this, it's important that you understand my policies. If there are any sections that you don't fully understand, please let me know. I'll be happy to further explain the policy and rationale. By initialing the sections below, you give your expressed consent and understanding of the following policies:

Consent for Services

I authorize Expressions Center for Communication Disorders, LLC to render appropriate evaluation and therapy services to the client named above in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional.

I understand and consent to services: _____

Plan of Care

Your child's plan of care is determined by a variety of factors. One factor is the interpretation of his/her test results, which might include a standardized assessment, informal measures, observation, and parent report. Another factor might include the opinions of your child's primary care physician or previous speech-language pathologist. All aspects of your child's plan of care will be reviewed with you, including frequency of treatment, treatment goals, session plans, and any materials or devices to augment behavior or communication (such as augmentative communication). Please remember that you are an important member of this team and your opinions are valuable. If at any point, you'd like amend or augment your child's plan of care, please let me know and we can arrange a meeting to do so. Additional fees may apply.

I understand and agree to POC policies: _____

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Payment

Expressions currently accepts: Medicaid, BCBS-AL, and private pay clients. ***Payment is required at time of service. If you are private pay, you understand that your entire balance is due at time of service. You are also responsible for any co-payments at time of service. If your insurance denies your claim or does not pay for the services in full, you are responsible for the amount not covered.*** Upon request, the SLP will provide a superbill for you to provide to your insurance company for potential reimbursement if we do not accept your insurance. **It is your responsibility to be familiar with your insurance plan. Presentation of a superbill may not ensure reimbursement from your insurance provider.**

Below is a fee schedule for services rendered:

Individual Speech/ Language Therapy Session (1 hour)	$60/**session**
Individual AAC Therapy Session (1 hour)	$75/**session**
Small Group Therapy Session (1.5 hours)	$75/**session**
Evaluation Services *includes initial consultations, correspondence with other medical and service providers, formal and informal assessment, a written report, and a debriefing session with family.*	$125/**evaluation**
AAC Evaluation *Includes initial consultations, correspondence with other medical and service providers, formal and informal assessment, a written report, a debriefing session with family, and filing paperwork for communication device with insurance (if applicable)*	$150/**evaluation**

Payments can be made through check, credit card, or PayPal. Fees are due **at the time services are rendered.** If a check is returned, a $30.00 fee may be added to your amount due.

I understand and agree to payment policies: _____

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Delinquent Payments

If fees are not paid in full within **7 days of being due**, treatment sessions may be postponed or cancelled. A $20.00 late fee will be added to delinquent accounts, per number of months delinquent. If the clinician is unable to collect the fee from a family, the delinquent account may be submitted to a collections agency at the family's expense. I understand that I am financially obligated for ALL costs related to the service(s) I receive. I further understand that if I do not make payment in full, my account may be reported to the credit bureau and/or turned over to an outside collection agency. I also understand that I will be responsible for the costs of the outside collection agency or legal fees associated with delinquent payments.

I understand and agree to delinquent payment policies: _____

Cancellations

In the event that the SLP has to cancel, you understand that the rescheduling of the session may or may not be possible. While the SLP will make every effort to maintain your treatment plan by rescheduling a session, make-up days/times are not always available.

In the event the parent/guardian needs to cancel, the following policies will apply:

- Cancellations will be accepted at least 6 hours in advance via text, voicemail, or phone call to 205-378-9447.
- Any cancellations after 6 hours are subject to a $30.00 fee.
- A “no show” occurs when the SLP arrives at your home and the client is either unavailable or cancels on the spot, or when the client does not arrive at the clinic for his/her scheduled appointment. A “no show” is subject to a $50.00 fee.
- We understand that things come up and life can sometimes be unexpected. Therefore, one “free” cancellation/no-show is allowed per 6 months. Please understand that I have to set these fees in order to cover the cost of my time and other services.
- A family member should contact the SLP if the client will be late to a session. The family will be responsible for the entire treatment/evaluation fee regardless of how tardy the client is to a session.
- Repeated cancellations/no shows/tardiness may result in the termination of services.
- I understand that I will receive a text or phone reminder up to 2 days prior to an assigned therapy time to limit “no shows.’”

I understand and agree to the cancellation policies: _____

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Termination of Services

Both the client and the SLP have the right, at any point, to terminate services. You also understand that repeated cancellations may result in termination of services. Termination of services may also occur after the child has completed his/her treatment plan, if a physician no longer finds a need for therapy services, or if a family is unable to pay out-of-pocket for services.

I understand and agree to termination policies: _____

Use of photo and likeness

****You have the right to opt out of these terms****

I give my express permission to Expressions Center for Communication Disorders, LLC to use the likeness/photo of my child for the purpose of:

_____ Therapy (i.e. for video modeling, data collection, video feedback, etc.)

_____ Marketing (i.e. use on website, pamphlets, flyers, etc.)

Initial beside the options for which you give consent

Acceptance of Responsibility:

I will not hold any employee or independent contractor employed by Expressions Center for Communication Disorders, LLC accountable for any losses, injuries or other damages occurring to the client and/or myself. I further understand that I am fully responsible for my own safety.

I understand and agree to accept responsibility as stated above: _____

Agreement of Terms

I have read the above terms and policies and fully understand each section, as indicated by my initials. The SLP has gone over this contract with me verbally and has addressed my questions and concerns fully and completely. I accept the terms and policies set forth and agree to abide by them.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Signature of Service Provider (SLP) Date