



Kirsten Cerroni, MS/CCC-SLP
W238 N1690 Rockwood Drive, #500
Waukesha, WI 53188
Direct 262-563-8140
Clinic 262-347-2222

Consent to Treatment, Policies, Financial Agreement

Please read and **initial** the following:

_____ 1. **Consent for Treatment:** I authorize Kidzspeech, LLC to perform speech/language/feeding/oral motor evaluations, administer therapeutic treatment, and provide clinical services as deemed necessary by Kidzspeech, LLC and Kirsten Cerroni, MS/CCC-SLP.

_____ 2. **Release of Information:** I authorize release of information to the referring doctor/agency. I further authorize Kidzspeech, LLC to use or release any records that it may have concerning me or my dependent to individuals or organizations necessary for obtaining payment from my insurance company. I understand that this authorization may be revoked in writing by me at any time and that such revocation will be effective as of the date such written revocation is received by Kidzspeech, LLC.

_____ 3. Scheduled appointment length is typically 60 minutes, which includes 50 minutes of contact time and 10 minutes for communication with parent, documentation, and planning for your next session. Coming late to an appointment may lead to a shorter appointment, still at the scheduled charge.

_____ 4. **Cancellation Policy:** 24-hour notice is expected for all cancellations. A cancellation fee of \$60 may be charged for failure to keep scheduled appointments unless 24-hour prior notice is given. **The full session fee will be charged for failure to keep scheduled appointments without prior notice.**

_____ 5. **Illness:** We try to keep our environment clean and try not to spread illness. Please keep your child home if he/she is sick. This includes copiously runny noses, excessive congestion or coughing, and fever. We reserve the right to refuse treatment if your child is demonstrating symptoms of illness.

_____ 6. **Confidentiality:** Kidzspeech, LLC works within the same environment as therapists employed by Special Therapies, Inc. During the course of your child's treatment session, he/she may be visible by other therapists and/or staff (not employed by Kidzspeech, LLC), other clients, and other parents and caregivers. Therapy sessions may be conducted in large rooms that are being shared with other therapists and clients. At times, with your permission, sessions may incorporate interaction/play with another child that is being seen by another therapist.

Financial Agreement

_____ I understand and agree with the following:

1. **Payment for treatment and evaluations is expected at the time of service, unless other arrangements have been made.** If you prefer, your insurance may be billed by this provider. Kidzspeech, LLC is an out-of-network provider. Since payment is due at the time-of-service, insurance reimbursement will be sent to you directly from your insurance company. If you choose not to have this provider bill your insurance, you may ask to be provided with a superbill that you may submit to your insurance company, or use for HSA reimbursement. **A discount of 10% of the therapy charges (evaluations, re-evaluations, and progress reports not included) will be given if this provider will not be billing your insurance on your behalf.**
2. **Evaluations and Re-evaluations:** Evaluation charges are based on time. Some evaluations will be shorter, and some will be more involved. Depending on the length of time needed, evaluation charges may be between \$275 and \$560. If a provider determines that a full evaluation is not necessary due to recently being completed at another facility, the initial visit charge will be \$240, which covers the



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initial visit, thorough review of records, and development of a plan of care. Re-evaluations may be conducted as needed, or typically once per year. You will be charged for a re-evaluation fee, based on time, if an evaluation is indicated. Therapist may deem that a re-evaluation is needed to update the plan of care. If this occurs more frequently than once per year, you will be notified of the re-evaluation.

- 3. **Re-evaluations and Progress Reports:** Re-evaluations may be done at the discretion of the therapist or at the request of clients. Re-evaluations are billed at the regular evaluation rate, and may or may not be reimbursable by insurance. Progress reports may be done at the discretion of the therapist, or at the request of a client or insurance company. Progress reports will be billed at the normal therapy rate based on time needed to complete the report. Progress reports may not be billed to insurance, and client's are responsible for payment.
- 4. **SPEECH THERAPY: \$120/session.** Session length is typically 50 minutes. For the remaining 10 minutes, the therapist will review the session and communicate with the caregiver.
- 5. **I understand that I am financially responsible for payment of all services at the time services are rendered,** unless otherwise agreed upon. I also understand that I am financially responsible for full payment of all services rendered and billed, regardless of payment received from my insurance company. **A 1% monthly finance charge, not to exceed 12% annually, is added to patient balances over 60 days.**
- 6. Additional reports that are not usual and customary are subject to a charge of 100% of the therapy hourly rate. This charge is not billable to insurance. Additional reports that are not considered usual and customary and incur a charge include, but are not limited to: insurance appeals and lengthy home programs.
- 7. Meetings/consultations and travel time to and from meetings are subject to a charge of 100% of the hourly therapy rate. This charge is not billable to insurance. Home visits incur travel charges at 100% of hourly therapy rates.
- 8. Phone consultations longer than 10 minutes may be charged at a pro-rated rate of \$120 per hour, using 15-minute increments.

I understand and agree to all of the above stated policies and fees. I understand that I am responsible for all debt incurred through Kidzspeech, LLC.

Patient Name

Date of Birth

Signature of Responsible Party

Date Signed

Printed Name of Responsible Party