COMMUNICATION FOUNDATIONS, LLC

Skills for Life

www.communicationfoundations.com
(860) 853-0205

Client Contract

I _____ hereby consent for Communication Foundations, LLC, to provide Speech-Language Therapy for:_____, D.O.B. __/___/_____. I understand that this agreement may be terminated by either party, in writing, at any time.

Professional Fees

___ Private Health Insurance _____ will be billed as my primary means of payment; should claims be denied as a result of changes/limitations in insurance coverage benefits, the private pay rate of $_____ per session will be charged. This rate also applies to missed/"no show" appointments as outlined below in the Cancellation/Missed Appointments section. I acknowledge that it is my responsibility to understand the coverage benefits, limitations, deductible and coinsurance amounts associated with my health insurance plan. I am responsible for any co-insurance/copayments not covered by my health insurance plan. It is my responsibility to notify Communication Foundations LLC immediately about plan changes/discontinuation of coverage, etc.____

OR

___ The Private Pay rate of $_____ per _____ min session will be charged to me. This rate also applies to missed/"no show" appointments as outlined below in the Cancellation/Missed Appointments section. ____

Payment/Insurance Co-payment is expected at the conclusion of each therapy session. This contract is subject to termination by Communication Foundations, LLC, if payment is not received within 3 business days of each session, unless otherwise mutually agreed upon in writing by Communication Foundations, LLC, and the party responsible for payment. _____

Missed Appointments/Cancellations (Client)

For *expected client absences* that result in a cancelled session(s) (e.,g., vacations, medical appointments, etc.), notice of cancellation is requested *at least one week prior* to scheduled therapy sessions. Every attempt will be made to reschedule sessions. ___

For *unexpected client absences* that would result in a cancelled session(s) (e.g., illnesses, life events, traumatic incidents, etc.), we request that you contact your therapist *immediately*. If an open appointment time is available within a 2 week window period, your session will be rescheduled. Appointments cancelled with less than 24 hours notice will incur a $25 charge; insurance may not be billed for this charge. ____

Failure to contact your therapist ("No Show") in advance of an absence will result in *full payment* for missed services; insurance will not be billed for "no show" appointments. If you fail to contact your therapist in advance of an absence, your session will not be rescheduled and you will be responsible for full payment. ____

In the event of consistent poor/missed attendance, client services may be subject to termination at the discretion of your therapist.____

Missed Appointments/Cancellations (Therapist)

For *expected therapist absences* that would result in a cancelled session(s) (e.g., vacations, conference attendance, etc.), notice of cancellation will be provided at least one week prior to scheduled therapy sessions. Expected therapist absences may not be rescheduled due to availability. ____

For *unexpected therapist absences* that would result in a cancelled session(s) (e.g., personal illness, illness of family member, life events, traumatic incidents, etc.), therapists will notify clients *immediately.* If therapy is cancelled by the therapist due to an unexpected personal emergency, therapists will make every effort to assign missed sessions to another therapist or reschedule sessions at a mutually agreeable time within a two-week window period of the cancelled session, if possible. Payment *will not* be expected for: (1) cancelled sessions due to expected therapist absences or (2) unexpected therapist absences that are *not able* to be reassigned or rescheduled. ____

Office Closing Procedures

Communication Foundations, LLC, follows the inclement weather policies of the Southington Public Schools. If Southington Public Schools are *closed* due to inclement weather conditions, Communication Foundations, LLC, will be closed unless you are contacted directly by your therapist. In the event of a *delayed opening* or *early*

dismissal, your therapist will contact you to determine the relative safety of meeting at your scheduled time. _____

Communication Foundations, LLC, may be closed for the observance of Holidays. Clients will be notified in advance of these closings. _____

Clients should arrive at least five minutes prior to their scheduled therapy time. Clients arriving more than fifteen minutes past their scheduled therapy time without notice of a reasonable delay will be considered a 'no show' and will be charged **full payment** for that session. _____

Communication Foundations, LLC, reserves the right to cancel or amend this contract, or any part therein without negating the remainder of the contract. Clients will be notified, in writing, of any changes or cancellation of this contract. _____

I have read and accept the terms of this contract.

_____ Date: _____ _____ Date: _____

Meredith Bandish, MA, CCC-SLP Client/Parent/Guardian
Owner