



**SPEECH SUPERSTARS**

3115 East Lion Lane, Suite 160, Salt Lake City, Utah 84121  
www.speechsuperstars.com Email: [jennifer@speechsuperstars.com](mailto:jennifer@speechsuperstars.com)

**Financial Policy**

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Thank you for choosing Speech Superstars to provide you with your child’s speech and language therapy services. We are pleased to participate in the care of your child and look forward to providing you with excellent therapy services. As part of this relationship, we wish to establish certain expectations of your financial responsibilities outlined in this policy.

**Payment Responsibility**

I understand as a recipient of medical care that I am responsible for all charges. I understand it is my responsibility to submit my own bills for reimbursement to my insurance company. I understand there is a fee charged for all Speech and Language visits, evaluations, therapy sessions, and medical reports. **I understand all services for Speech Superstars are billed as “private pay”.**

**Missed Appointment Policy**

I understand the outcome of treatment depends highly on keeping scheduled appointments that are reserved. Speech Superstars reserves the right to charge \$50 for missed appointments or cancellations without a 24-hour advance notice.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date



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**Financial Policy (cont'd.)**

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

**Returned Checks**

There is a \$35 charge for any returned check in addition to the original amount of the check. This must be paid by cash or cashier's check.

**Delinquent Accounts**

If your account becomes past due with nonpayment over 30 days, we will take the necessary steps to collect this debt.

**Acknowledgment**

I understand that as part of my care, Speech Superstars will originate and maintain paper and/or electronic records describing my child's health history, symptoms, evaluation, testing results, diagnostic treatment, and any plans for future care or treatment.

By signing this document, I also acknowledge that I have received and understand a copy of Speech Superstars, LLC's Notice of Privacy Practices. This acknowledgment is required by the Health Insurance Portability and Accountability Act (HIPPA) to ensure that I have been made aware of my privacy rights and privileges.

***I have read the updated financial policy and agree to all of its terms. All questions have been answered prior to my signing this financial policy document.***

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_