Upstate Pediatric Speech Therapy Services, Inc.
310 New Neely Ferry Rd. Mauldin, SC 29662
Office 864-438-0990 Fax 864-478-8383
www.pedspeechtherapy.com

# AGREEMENT TO TERMS OF PAYMENT

I acknowledge and accept full and complete responsibility for payment of all services rendered to me by Shannon L. Williamson, Ph.D., CCC-SLP, or by any employee of Upstate Pediatric Speech Therapy Services, Inc.

I realize that if I do not have insurance plan benefits then I am responsible for payment in full. If I am under an insurance plan and have not met a deductible, I agree to payment in full as allowed by your insurance plan. If eligibility is available under a private insurance plan, I agree to pay all co-payments/co-insurance amounts not reimbursed under the medical part of my plan.

I understand that payment is due at the time service is rendered. Bills will be generated once monthly for all treatments occurring that month. If a balance is not paid by the next treatment session, the balance owing will become due and collectible along with late penalty fee. I am aware that if payment is not made by the next scheduled treatment session, Dr. Williamson reserves the right to halt services until payment is made in full.

I understand that if my health plan coverage or insurance benefits become terminated or suspended, I am still responsible for payment and will be billed accordingly.

I agree to allow this office to release any information that is requested by my insurance company or health care plan.

You will not be billed for cancelled appointments (by the therapist). Please allow 24 hours notice to cancel appointments by the patient.

Name of Patient:_____ DOB: _____

_____ _____

Date Signature of Parent/Legal Guardian