Children's Speech Therapy Services, LLC
Jennifer S. Gaum, MA, CCC-SLP
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ChildsSpeech@gmail.com
240.426.8401

The following contract represents an agreement between Jennifer Gaum, owner and operator of Children's Speech Therapy Services, LLC, 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, and I'd 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

Your initials below give permission to me, Jennifer Gaum SLP, to perform therapy or evaluation services with the aforementioned child. Your initials also indicate that you have reviewed your child's plan of care with me and understand the nature of services to be performed.

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. 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 to 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 the POC policies _____

Payment

Below is a fee schedule for services rendered.

Service(s)	Fee
Treatment Services	$150/session
Informal Speech and Language Screening	$175/ screening
Speech and Language Evaluation Services (Includes initial consultation, correspondence with other medical and service providers, formal and informal assessment, a written report, and a debriefing session with family. May take place over 1-2 sessions.)	$500/evaluation
Speech (Articulation) Evaluation Services (Includes initial consultation, correspondence with other medical and service providers, formal and informal assessment, a written report, and a debriefing session with family. May take place over 1-2 sessions.)	$300/evaluation

*If for any reason, you are not able to pay your bill, please contact me immediately to work out a payment plan. I am happy to work around any short-term financial hardships or unforeseen circumstances. I never want your child to go without needed therapy services due to inability to pay.

I, the undersigned, certify that I (or my dependent) understand that I am financially responsible for all charges whether or not paid by insurances. I hereby authorize Children's Speech Therapy Services, LLC to release all information necessary to secure the payments of benefits.

I understand the payment policies_____

Delinquent Payments

All fees must be paid within 30 days of receipt. If fees are not paid in full, treatment sessions may be postponed or cancelled. A 10% late fee will be added

to delinquent accounts, per number of months delinquent. Fees will be accrued on the entire balance, including late fees from prior months. Whenever a check, draft or money order issued in payment of any fee or for any purpose is returned as uncollectible, a fee of $40 or 5% of the face amount of the check will be charged, whichever is greater. This fee is in addition to any bank fees and the amount of the check or money order. If the clinician is unable to collect her fee from a family, the delinquent account may be submitted to a collections agency at the family's expense. The overdue account may also be reported to a Credit Bureau.

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, any legal fees, and any bounced check fees, which will add significant costs to my account balance.

I understand the 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.

Cancellation fees will be used to cover the cost of planning your child’s treatment session, gas (when applicable), and loss of treatment time. Please understand that I must set these fees in order to compensate for my time/resources in the event of cancellations/no shows. Your cooperation with this matter helps keep therapy costs low. In the event the parent/guardian needs to cancel, the following policies will apply:

- Cancellations will be accepted at least 4 hours in advance via text, voicemail, or phone call to 240-426-8401
- Any cancellations accepted after 4 hours are subject to a $20 fee.
- A “no show” occurs when the SLP arrives at your home and the client is either unavailable or cancels on the spot. A “no show” is subject to a $50 fee.
- Cancellation/no show fees will be billed directly to the client.
- Repeated cancellations/no shows/tardiness may result in the termination of services.
- I understand that things come up and life can sometimes be unexpected. Therefore, one “free” cancellation 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.

I understand the cancellation policies _____

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 the termination policies _____

Notice of health privacy policy (HIPPA)

I hereby declare that I have been offered a copy of my health privacy policy.

_____ _____
Signature of Patient/Responsible Party Relationship to Patient
Date

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 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 Relationship to Patient
Date

_____
Signature of Service Provider (SLP)
Date