Bliss Speech and Hearing Services, Inc.
12700 Hillcrest Road, Suite 207 · Dallas, TX 75230-2068
Phone: (972) 387-2824 • FAX: (972) 387-9097 • www.blissspeech.com

To Whom It May Concern:

Thank you for choosing Bliss Speech and Hearing Services, Inc. as your healthcare provider. We appreciate your trust and the opportunity to serve you.

Enclosed you will find copies of the Financial Policy and Payors Responsibility forms. Should you have any questions, please let the front office know as we will be happy to discuss our policies with you. Should you request it, you will be provided with a copy of your signed policies at the end of your visit.

In addition, please see the attached Patient Information Form, as well as other forms that will assist Bliss Speech and Hearing Services, Inc. in better serving you. Once you complete the forms, you can return them to the front office.

We look forward to working with you.

Sincerely yours,

Brenda Bliss, M.S., CCC-SLP/A, LSLS Cert. AVT
Director, Bliss Speech and Hearing Services, Inc.

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CHILD CASE HISTORY

PLEASE PRINT AND COMPLETE ALL ENTRIES

CHILD'S NAME:_____DATE OF BIRTH:_____AGE:_____SEX:_____

ADDRESS:_____
city state zip

HOME PHONE NO: (_____)_____ (if different from cell phone)

FATHER'S NAME:_____AGE:_____ DL#_____

ADDRESS (if different from child):_____
city state zip

CELL PHONE: (_____)_____ EMAIL ADDRESS_____

EMPLOYER:_____BUSINESS PHONE NO: (_____)_____

BUSINESS ADDRESS:_____OCCUPATION:_____

MOTHER'S NAME:_____AGE:_____ DL#_____

ADDRESS (if different from child):_____
city state zip

CELL PHONE: (_____)_____ EMAIL ADDRESS_____

EMPLOYER:_____BUSINESS PHONE NO: (_____)_____

BUSINESS ADDRESS:_____OCCUPATION:_____

EMERGENCY CONTACT (Different from individuals listed above): _____PHONE:(____) _____

PEDIATRICIAN (FAMILY DOCTOR):_____PHONE NO:_____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____

REFERRED BY:_____

REASON FOR REFERRAL:_____

INSURANCE INFORMATION

INSURANCE NAME:_____PROIVER LINE PHONE NO:(_____)_____

EMPLOYER NAME:_____

NAME OF POLICY HOLDER:_____ RELATIONSHIP TO PATIENT:_____

DATE OF BIRTH:_____ ID NO:_____ GROUP NO:_____

BLISS SPEECH AND HEARING SERVICES, INC.
12700 HILLCREST ROAD, SUITE 207
DALLAS, TEXAS 75230

PAYORS RESPONSIBILITY

Thank you for choosing Bliss Speech and Hearing Services, Inc. as your health care provider. We are committed to the success of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any intervention.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, or VISA/MASTERCARD.

Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to contract. Therefore, all payments are due in full at the time of your visit. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable, customary and/or medically necessary under your medical insurance plan. **We are not responsible for any charges your insurance company considers to be in excess of reasonable or customary fees as well as those considered medically unnecessary.**

By the execution hereof, the undersigned acknowledges his/her/their responsibility to pay any amounts not paid or reimbursed by insurance. The undersigned specifically accepts all financial responsibility for all services provided to the herein named patient by BLISS SPEECH AND HEARING SERVICES, INC. and understands that regardless of what the insurance company agrees to pay, the undersigned will be responsible for the balance. Said balance will be paid without regard to the status of processing by the insurance carrier.

The undersigned does hereby acknowledge that he/she shall be fully responsible for the payment to the provider, BLISS SPEECH AND HEARING SERVICES, INC., of the amount BLISS SPEECH AND HEARING SERVICES, INC. bills for any services that are identified as Non-Covered Services by the undersigned's insurance company.

Notwithstanding anything contained hereinabove to the contrary, should the undersigned be covered by a Preferred Provider Plan (PPO) for which we are a provider, and said plan calls for CO-PAY, the insured will pay, in full, all invoices at the time of **each visit** until such time as the services provided by BLISS SPEECH AND HEARING SERVICES, INC. within fifteen days of said determination. Once the patient has been approved under the PPO plan, all co-pays and deductibles will be due to prior to the treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

Change in Insurance Plan

Should your insurance change for any reason, you are responsible for notifying us in writing. Failure to notify us in writing will cause you to be responsible for any losses incurred by Bliss Speech and Hearing Services, Inc. due to said failure.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of what is usual and customary rates.

PAYORS RESPONSIBILITY

Report Writing Fees

The adult patient or parent (or guardians of the minor) or the adult accompanying a minor patient, shall be responsible for paying fees assessed by Bliss Speech and Hearing Services, Inc. for the preparation of reports required by their insurance company so the insurance company is able to determine medical necessity and/or, if not otherwise covered by their insurance, for pre-authorizations. In addition, the adult patient or parent (or guardians of the minor) or the adult accompanying a minor patient, shall be responsible for paying fees assessed by Bliss Speech and Hearing Services, Inc. for the preparation of reports for their physicians, schools, personal records, and other purposes.

Adult Patients

Adult patients are responsible for full payment at time of service.

Minor Patients

The parent (or guardians of the minor) or the adult accompanying a minor is responsible for **full** payment. For unaccompanied minors, treatment will be denied unless charges have been preauthorized to an approved credit plan, Visa/ MasterCard, or payment by cash or check at time of service has been verified.

Missed appointments

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Other billing items

Periodically**,** school visits, parent conferences, and various off-site visits will be scheduled in an effort to develop a more comprehensive therapy plan. The hourly rate will be billed for these meetings, to include transportation to and from the off-site visit. Requested or necessary reports are billed at the regular hourly rate.

Release of information

See the accompanying Notice of Privacy Practices for policies pertaining to Protect Health Information (PHI).

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy:

x_____ Date_____
Signature of Patient or Responsible Party

x_____ Date_____
Signature of Co-Responsible Party

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FINANCIAL RESPONSIBILITY

A) When you contact our office to schedule an evaluation, we will request your insurance information so that we may contact your insurance company in order to determine the insurance benefits to which you might be entitled. Once benefits are determined, we will advise you of the benefits outlined which may be subject to certain terms as contained in the agreement between you and your insurance company.

B) After we complete the initial evaluation, we will send the test results, a treatment plan and all medical information that may be pertinent to your case to your insurance company. It typically takes four to six weeks for the insurance company to review the information and make a determination as to whether the therapy services are approved for coverage by your insurance company.

C) During the time period between your initial evaluation and obtaining a determination of benefits from your insurance company, you may choose to either:

Begin therapy sessions, paying privately for each session before each visit. Should coverage be approved and paid by your insurance company, we will promptly reimburse you for those funds you paid to us, less co-pays, co-insurance and/or your deductible (whichever is applicable).

OR

Forgo treatment until the determination is received.

Please be advised that the financial responsibility for medical services rests between you and your insurance company. While we are willing to file directly to your medical insurance for you, please be advised that we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies a claim for any reason, our office cannot be responsible for the bill. It is your responsibility as a patient to know exclusions and regulations of your plan.

Our primary mission is to provide you with quality, cost effective care. Together, we are trying to adapt to the changing way healthcare is financed and delivered. We value you as a patient, and our top priority is to provide you with the best possible care. Please feel free to let us know if you have additional questions.

Sincerely,

Brenda Bliss, M.S., CCC-SLP/A, LSLS Cert. AVT
Director, Bliss Speech and Hearing Services, Inc.

I have read and understand my obligations and acknowledge that I am fully responsible for payment of services not covered by my insurance carrier.

_____ _____

Parent/Guardian Patient Printed Name

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NON-COVERED SERVICE(S) AGREEMENT

The undersigned does hereby acknowledge that he/she shall be fully responsible for the payment to the provider, BLISS SPEECH AND HEARING SERVICES, INC., of the amount BLISS SPEECH AND HEARING SERVICES, INC. bills for services that are identified as Non-Covered Services by the undersigned's insurance company:

_____

Name of Patient

_____

Name of Parent/Guardian

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Signature of Co-Responsible Party Date

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CANCELLATION POLICY

ALL APPOINTMENTS MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE. YOU WILL BE CHARGED FOR APPOINTMENTS NOT CANCELLED AT LEAST 24 HOURS IN ADVANCE. INSURANCE COMPANIES DO NOT COVER THIS EXPENSE; THIS WILL BE THE SOLE RESPONSIBILITY OF THE PATIENT. I UNDERSTAND AND AGREE TO THIS CANCELLATION POLICY.

_____

PARENT SIGNITURE

Bliss Speech and Hearing Services, Inc.
12700 Hillcrest Road, Suite 207 · Dallas, TX 75230-2068
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ASSIGNMENT OF BENEFITS

By the execution hereof, the undersigned authorizes payment of medical benefits to Bliss Speech and Hearing Services, Inc. I also authorize the release of any in formation necessary to process any claims.

_____
PATIENT NAME

_____
PARENT SIGNATURE

_____
SUBSCRIBERS/PARENT SIGNATURE

_____
TODAY DATE

_____
PATIENT ADDRESS

_____
CITY STATE ZIP

BLISS SPEECH AND HEARING SERVICES, INC.
Brenda Weinfeld Bliss, M.S., CCC-SLP/A. Cert. AVT
Licensed Speech-Language Pathologist/Audiologist

I, _____ give Bliss Speech and Hearing Services, Inc.
(Name)
authorization to send a copy of my child's evaluation report to the following:

☐ Physician: _____
(Name)

_____
(Address)

_____

☐ School: _____
(Name)

_____
(Address)

_____

☐ Other: _____
(Name)

_____
(Address)

_____

I also authorize the release of any information necessary to my Health Insurance Company for the processing of claims.

I understand that I shall be responsible for paying fees assessed by Bliss Speech and Hearing Services, Inc. for the preparation of reports required by the insurance company so the insurance company is able to determine medical necessity and/or, if not otherwise covered by the insurance, for pre-authorizations. In addition, I acknowledge I shall be responsible for paying fees assessed by Bliss Speech and Hearing Services, Inc. for the preparation of reports for physicians, schools, personal records, and other purposes.

_____ _____
Signature Date

Bliss Speech and Hearing Services, Inc.

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Acknowledge of Notice of Privacy Practices (HIPAA)

My signature on this form indicates that I have been given the opportunity turn review a Notice of Privacy Practices (HIPAA).

_____

Name of Patient

_____

Name of Parent/Guardian

_____ _____

Signature Date

If you have any questions, please contact the Privacy Officer:

Ron I. Bliss
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Dallas, TX 75230
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CONSENT FOR EMAILS/TEXT MESSAGES

Childs Name: _____

Parents Name: _____

Communication via email and/or text message allows Bliss Speech and Hearing Services, Inc. to exchange information efficiently for the benefit of our patients. At the same time, we recognize that email and text messaging are not a completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly while in storage or during transmission.

If you would like us to send you email and/or text messages that contains your child's personal information, please complete and sign this Consent below. You are not required to authorize the use of email and/or text messaging and a decision not to sign this authorization will not affect your health care in any way. If you prefer not to authorize the use of email and/or text messaging, we will continue to use U.S. mail or telephone to communicate with you.

Additionally, when communicating by phone, we realize there will times you cannot answer our call. If we are unable to reach you, we should:

☐ leave a detailed message

☐ leave a message asking you to return our call/email

Email address to which Bliss Speech and Hearing Services, Inc. may send YOU your child's personal information:

_____
(Please Print)

Phone number to which Bliss Speech and Hearing Services, Inc. may contact you:

_____

Parent Signature: _____ Date: _____