# PAYMENT POLICY

Uplift Speech Therapy Services is currently an in-network provider for TRICARE. If your current insurance provider is TRICARE, benefits will cover payments for the evaluation and therapy. Uplift Speech Therapy Services will bill TRICARE for evaluations and therapy.

Uplift Speech Therapy Services also accepts private/out-of-pocket payment. It is the responsibility of the patient/parent/guardian to fill all non-TRICARE insurance claims if you so choose. Uplift Speech Therapy Services will provide clients with a detailed invoice for services rendered that can be submitted for insurance claims by the patient/parent/guardian upon request. Please note that it is the responsibility of the patient/parent/guardian to contact their insurance carrier to determine the required documentation for filing insurance claims. Uplift Speech Therapy Services is not responsible for out-of-network non-reimbursement but will provide additional documentation if needed for insurance providers at the request of the patient/parent/guardian.

In-network patients will be billed based on the insurance providers billing schedule. If a co-payment is required by insurance it is due at time of service. For private pay patients, payment is due at time of service. If you pay by check and the check bounces, you will be charged a $25 fee.

Please notify Uplift Speech Therapy Services if the patient's physician or insurance coverage changes.

***Families are responsible for checking their financial responsibilities with their insurance carrier. It is not the responsibility of Uplift Speech Therapy Services to provide benefit information. Should actual coverage be different than what was quoted by your carrier, contact your insurance carrier directly. Payment is still expected by Uplift Speech Therapy Services, we will not wait for insurance to make adjustments. Families will be responsible for all payment not covered by insurance.***

As the patient/parent/guardian, I have read the above information and understand Uplift Speech Therapy Services' Payment Policy. I accept all terms and conditions.

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Printed Name of Patient/Parent/Guardian    Relationship to Patient

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Signature    Date