

Vegas Voice Institute

CONSENT FOR TREATMENT AGREEMENT

Patient Information		
Name:	SSN#:	DOB:
Age: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female		
Address:		
City:	State:	Zip Code:
Home Phone:	Office Phone:	Cell Phone:
Employer:	Occupation:	
Emergency Contact:	Phone:	
Who were you referred by?		
E-mail address:		
Would you prefer to get reminder calls by telephone or email: <input type="checkbox"/> Telephone <input type="checkbox"/> Email		
Insurance Information:		
Primary Insurance:	Group #	Policy#:
Subscriber's Name:	Relationship to Patient:	Subscribers #
Claims Address:		
_____	_____	_____
Street	City/State	Zip Code
Phone:	Fax:	
Secondary Insurance:	Group #	Policy#:
Subscriber's Name:	Relationship to Patient:	Subscribers #
Claims Address:		
_____	_____	_____
Street	City/State	Zip Code
Phone:	Fax:	
Medicare Part B Medical Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare # _____		

PRE-AUTHORIZATION FOR TREATMENT

Some medical insurance carriers require prior approval for treatment. It is your responsibility to know if your insurance company has these requirements and to inform our office so we may request the appropriate authorization.

If you do not provide us with the appropriate insurance information prior to treatment, you will be held financially responsible for any visits that are not covered because authorization was not obtained.

INSURANCE AND BILLING

The financial obligation for this account is yours. We are happy to bill your insurance as a courtesy to you and will do all that we can to collect on legitimate claims. It is up to you to provide our office with full and correct insurance information, as well as any forms that may be required. In the event your insurance company is slow to pay or denies the claim for any reason, we will look to you for payment of this account. If we are an out-of-network provider you will be asked to pay cash during each session and you will need to obtain a reimbursement form from your insurance by calling member services.

ASSIGNMENT OF BENEFITS

I hereby assign and direct you to pay any medical benefits under this claim directly to Linda L. Ganz – Vegas Voice Institute.

I hereby assign any injury benefits due to a liability of a third party, payable by any party for the above patient to Vegas Voice Institute.

I hereby authorize above firm to furnish from its records any information requested by the above named insurance companies in connection with the above assignments.

I do hereby appoint Vegas Voice Institute as my lawful agent ONLY for the purpose of endorsing and depositing checks made payable to me for benefits or claims collected under the above assignments and to apply any credit balance to any account I may owe above stated firm.

All balances, after maximum insurance payment has been received, are due and payable upon receipt of last insurance monies received. A late fee of \$20 per month will be added to all accounts 30 days past due. In the event this account is given to an attorney, or an agency for collection, the patient/responsible party agrees to pay reasonable attorney fees, legal fees, and lawful collection costs in addition to all sums due thereafter.

Cancellation and no show policy: I understand that I must give at least 24 hours notice of a cancellation of a speech therapy session which can be made by making contact with Vegas Voice Institute by contacting our office. I also understand that if at anytime I “no call, no show” for a scheduled appointment or do not give a 24 hour notice for a cancelled therapy session, I will be charged a \$50 fee on the first occurrence and \$125 for each occurrence thereafter. This fee must be paid in full before another scheduled appointment can be made. Any cash pay patient will be responsible for the entire fee. If participant in therapy incurs more than 1 no show or 2 cancellations, participant will be subject to discharge from the therapist’s caseload as determined by the therapist.

Patient: _____ Date: _____

I acknowledge by my signature that I have read the above and agree to the stated terms. I also acknowledge that I received a copy of the Notice of Privacy Practices.