



10810 Darnestown Road, Suite 102 North Potomac, MD 20878
Phone/Fax: 240-200-5305

Anat Sohn, M.A., CCC-SLP
Metro Speech Therapy, LLC
Pediatric and Adult Speech-Language Pathologist
MD License Number: 05839

Payment for Services

For your convenience, we accept cash, checks, credit cards and debit cards. Payments will be made at the time of service and a receipt will be sent to you via email.

Please sign and return the Credit Card/ Debit Transaction Form along with the remainder of the forms. All correspondences regarding billing should be emailed to this address: anat@metrospeech.com

Cancellation and No-Show Policy

“No Shows” or Cancellations with less than 24 hours from your scheduled appointment will be billed \$30. For all cancellations, please call or text (240) 200-5305.

We greatly appreciate as much advanced notice as possible for vacations or other events for which you are unable to keep your appointment.



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CREDIT CARD/ DEBIT TRANSACTION PROCESSING AUTHORIZATION

_____ Yes, I would like you to automatically charge my credit card for services rendered.

CARD TYPE	NUMBER	EXP. DATE	3 DIGIT CODE ON BACK
_____ <i>Visa</i>	_____	_____	_____

Billing Address and Name on the card: _____

CARD TYPE	NUMBER	EXP. DATE	3 DIGIT CODE ON BACK
_____ <i>MasterCard</i>	_____	_____	_____

Billing address and Name on the card: _____

CARD TYPE	NUMBER	EXP. DATE	4 DIGIT CODE ON FRONT
_____ <i>American Express</i>	_____	_____	_____

Billing address and Name on the card: _____

By signing this Agreement, and marking the box noted above, the undersigned does hereby agree as follows: (i) the undersigned does hereby authorize and agree that Anat Sohn, M.A., CCC-SLP and/or its duly authorized agent (Metro Speech Therapy, LLC) has the right to charge to the above identified credit card and/or debit the account identified above any and all amounts that are owed to the Company and/or its consultants, (ii) the undersigned agrees that its signature on this Agreement shall be deemed its signature on any sales charge receipt or other form and if any merchant services, credit card company, or bank requests to view the undersigned signature on a sales charge receipt or other form, the Company may provide such company with a copy of this Agreement and such shall be deemed conclusive proof that the undersigned approved and authorized the charge and/or debit at issue, and the undersigned does hereby waive any right to dispute its authorization to such charge based on an invalid or non-existent signature. The undersigned understands and agrees that the above payment option and charges or debits will continue each month for services rendered by the Company and/or its consultants until such time as the undersigned has provided written notice to the Company to stop such automatic charges and/or debits. The undersigned shall be fully responsible for ensuring that it has sufficient credit and/or funds to cover the charges or debits, and shall indemnify the Company against all costs incurred as a result of any declined charge or debit.

AGREED AND ACCEPTED

I, _____ (*print name*) authorize Metro Speech Therapy, LLC to charge my debit/credit card and send paid invoices via electronic mail _____ (email address).

I acknowledge and accept full and complete responsibility for payment of all services rendered by Metro Speech Therapy, Anat Sohn, M.A., CCC- SLP, and/or its consultants. I acknowledge that I have received written explanation of the cancellation policy and payment policy and I agree to both.

I understand that health insurance policies are an arrangement between my insurance company and myself, that all services rendered are charged directly to me, and that I am personally responsible for payment. I understand that agreements regarding fee schedules, charges for cancelled appointments and late payment fees are between Metro Speech Therapy, LLC and myself and are not related to potential insurance coverage. I understand that Anat Sohn, M.A., CCC-SLP may assist me in completing forms to aid in collecting insurance benefits for services that are billable, but ultimately it is my responsibility to complete and file such forms. I agree to the release by Metro Speech Therapy, LLC and/or its duly authorized agents of any information that is requested by my insurance company.

Signature of client /(parent or legal guardian)

Date

INSURANCE INFORMATION

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Name of Primary Insurance Company: _____

Insurance Company Phone# (Provider line): _____

ID #: _____ Group #: _____

Card Holder's name: _____ Card Holder's DOB: _____

Name of Secondary Insurance Company: _____

Insurance Company Phone# (provider line): _____

ID #: _____ Group #: _____

Card Holder's name: _____ Card Holder's DOB: _____

Agreement to Terms of Payment (insurance)

I, _____ (*print name*), acknowledge and accept full and complete responsibility for payment of all services rendered by Metro Speech Therapy, Anat Sohn, M.A., CCC- SLP, and/or its consultants that are not covered by my health insurance plan. I acknowledge that I have received written explanation of the cancellation policy, and payment policy and I am in agreement.

I understand that I am responsible for my copay at the time services are rendered and Metro Speech Therapy, LLC will submit claims to my health insurance company on my behalf. I understand that all payments on claims that are denied by my health insurance company are my responsibility and that all services rendered that are not covered by my health insurance company are charged directly to me. I understand that agreements regarding fee schedules, charges for cancelled appointments and late payment fees are between Metro Speech Therapy, LLC and myself and are not related to potential insurance coverage. I understand that Anat Sohn, M.A., CCC-SLP will complete forms on my behalf in collecting insurance benefits for services that are billable. I agree to the release by Metro Speech Therapy, LLC and/or its duly authorized agents of any information that is requested by my insurance company.

Signature of client /(parent or legal guardian)

Date

ACKNOWLEDGEMENT AND ASSUMPTION OF RISK 5

I, _____ (*print name*) acknowledge and agree to have my child (or the child under my care), _____ (*print child's name*) receive speech therapy services from Anat Sohn, M.A., CCC-SLP and/or any independent contractor under the foregoing at Metro Speech Therapy, LLC. I acknowledge that there is some risk inherent in the use of the therapy equipment and I agree to assume such risk and indemnify and hold Anat Sohn, M.A., CCC-SLP, any of their independent contractors, and Metro Speech Therapy, LLC harmless from any and all losses and claims for any injuries or other damages occurring to myself, my child or our belongings.

Signature of client /(parent or legal guardian)

Date

VIDEO RECORDING ACKNOWLEDGEMENT AND CONSENT FORM

I, _____ (*print name*), understand that Metro Speech Therapy, Anat Sohn, M.A., CCC-SLP, and their consultants (hereinafter, the “Company”) may use video recording and related equipment for diagnostic and treatment planning purposes.

I further consent to the use of the video by the Company for the purpose of training personnel in the health care and education fields. I understand that if the Company uses the video for training purposes, the Company will inform us of this intention. I understand that the Company will protect the family’s identity and will disclose only those details about the child’s condition and treatment process necessary for training purposes. Accordingly, by signing below, the undersigned does hereby release and waive any and all rights that the undersigned may have in the videos, and assigns such rights to the Company to be used in accordance with the terms of this Consent Form.

Signature

Date

PROFESSIONAL CONTACT FORM

School: _____

Address: _____

Telephone: _____

Teacher: _____

Telephone: _____

Occupational Therapist: _____

Telephone: _____

Address: _____

Physical Therapist: _____

Telephone: _____

Address: _____

Speech-Language Pathologist: _____

Telephone: _____

Address: _____

Physician: _____

Telephone: _____

Address: _____

Psychologist/Psychiatrist (circle one): _____

Telephone: _____

Address: _____

Educational Consultant: _____

Telephone: _____

Address: _____

ABA Therapist: _____

Telephone: _____

Address: _____

Neurologist: _____

Telephone: _____

Address: _____

Other Professional: _____

Telephone: _____

Address: _____

CONSENT TO RELEASE INFORMATION FORM 7

I, _____ (*print name*) give my permission and consent to Metro Speech Therapy, Anat Sohn, M.A., CCC-SLP, and their respective consultants and agents (hereinafter, collectively, the “Company”) to discuss and speak with school officials, teachers, psychiatrists, medical doctors, other therapists, insurance representatives, and other professionals (collectively, “Third Party Professionals”) regarding my child (or the child under my care) as such may be needed in connection with the treatment and/or evaluation of such child by the Company.

In addition, the Company is authorized to receive any records, files, charts, and other documentation and information from such Third Party Professionals, and by signing this document, the undersigned is authorizing the release of any such information that may be held by a Third Party Professional to the Company. Any person who is provided a copy of this document may rely on it as the undersigned’s full and unconditional consent to the release of any and all information pertaining to the child. The undersigned further authorizes the Company to release any and all information pertaining to the treatment and/or evaluation of the child to any Third Party Professional that may in any way be involved in the treatment and/or evaluation of the child.

The undersigned understands that some or all of the information obtained and/or released under this document may be protected under federal regulations including but not limited to HIPAA. By authorizing a release of information, as set forth above, the undersigned understands and agrees that they are agreeing to the release of such information notwithstanding the protections under HIPPA, provided, however, it is understood and agreed that the Company will maintain the confidentiality of any information obtained and will not disclose the same except as needed in the course of treating or evaluating the child.

The undersigned, for his/herself and his or her successors and assigns, does hereby hold the Company harmless from any and all claims relating to the release of information as provided above, and do hereby waive and release any claim against the Company relating to the release of such information as provided above.

Signature (parent or legal guardian)

Date

PARENTAL/CONSENT FOR SCHOOL OBSERVATION FORM

I, _____ (*print name*), give my permission to Metro Speech Therapy, Anat Sohn, M.A., CCC-SLP, and their consultants (hereinafter, collectively, the “Company”) to observe my child (or the child under my care) _____, at _____ School. I understand that during this observation, the Company may speak with the classroom teacher and other professionals at the school about my child.

Signature

Date

I do hereby acknowledge and agree that: (i) I have read all of the forms and documents provided to me in connection with the treatment and evaluation of my child (or the child under my care) by Metro Speech Therapy, Anat Sohn, M.A., CCC-SLP, and/or their respective consultants; (ii) I understand the meaning and intent of such forms, and agree to the provisions contained therein; (iii) I have been given the opportunity to ask questions concerning the forms and any questions that I have asked have been answered to my satisfaction, and (iv) I have signed all of the forms upon my own free volition and without any coercion from any third party.

Print Name

Signature (Parent or Legal Guardian)

Date