Big Apple Speech Therapy, LLC
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PATIENT RESPONSIBILITY FORM

We are honored by your choice and are committed to providing you with the highest quality of treatment. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

INDIVIDUAL'S FINANACIAL RESPONSBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at the time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines services to be "not medically necessary" or "not payable," I will be responsible for the complete charge and agree to pay the costs of all services rendered.
- If private pay, I agree to pay for the services rendered at time of service.

If you have any questions, please feel free to ask Susie Appleman, Director.

Date: _____

_____
Signature of Patient or Authorized Representative or Responsible Party

_____
Print Name of Patient & Responsible Party