



Financial Policy 2025

Please Read and Sign Before Your First Appointment

Garrison City Speech & Language Services (GCS&LS) is a participating provider for **Aetna, Ambetter, AmeriHealth Caritas, Blue Cross/Blue Shield, Cigna, Harvard Pilgrim Healthcare, Health Plans, Inc., Martin's Point Health Care, Mass General Brigham Health Plan, NH Healthy Families, NH Medicaid, Tricare East, Tufts Health Plan, United Healthcare and Well Sense**. Patients with these insurance plans will be required to pay the deductible, co-payments, co-insurance and non-covered services (i.e., consultations, attendance at IEP meetings) if applicable. GCS&LS **does not** accept Medicare.

It is the patient's responsibility to provide ALL insurance policies to GCS&LS.

Please provide credit card information to be maintained on file:

Your account will be automatically charged on the date of service for co-payments, co-insurance and deductibles. Your account will be charged within 5 days of receiving adjudication from your insurance for the patient balance due if there is one.

Credit Card # _____ **Exp Date:** ____/____

Name on Card: _____ **3-digit CVV#** ____
 First **MI** **Last**

Billing Zip Code: _____

For non-participating insurance plans or for patients without insurance benefits, payment is due in full on the day of service. A detailed receipt will be provided to those with non-participating insurance plans to submit for coverage of out-of-network benefits.

If insurance payments have not been received by GCS&LS within 45 business days from the date of service, you will automatically be billed for the total due. You will be issued a refund check if/when the payment is received by the insurance company.

Patients/legal guardians are responsible for maintaining their insurance policies. If policies become inactive for any reason and services are rendered, the patient is responsible for the bill in full on the date of service.

Professional services are rendered and billed to the patient, **NOT the insurance company**. GCS&LS will submit claims to the above listed insurance companies directly as a courtesy to you. GCS&LS is not employed by the insurance company. If for **any reason** the insurance company denies payment, you are **responsible for the total amount billed to you within 30 days** of the invoice date.

Patients/legal guardians are responsible for knowing their insurance benefits. Please be sure to review your insurance booklet and policy **AND** contact your insurance company's Benefits and Eligibility Department to determine if services are covered and what is required before the initiation of services.

By signing below, you agree to the above financial policy and understand that if your account becomes delinquent, you will be responsible for collection agency fees and/or attorney/court fees. There will be a \$35.00 charge for returned checks and either a \$25.00 or 50% service charge per month (whichever is less) for invoices not paid within 30 days of the invoice date. GCS&LS accepts cash, checks, money orders or major credit cards as payment.

Print Patient's Name: _____

Patient's Signature: _____ **Date:** _____

(Parent/Guardian Signature if patient is under 18)