Terms & Conditions Agreement

Thank you for choosing Technology & Language Center, Inc. (TALC) for your augmentative and alternative communication (AAC) and speech-language pathology needs. This Terms & Conditions Agreement details patient and insurance responsibility for services rendered. Please read it carefully, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We are in ONLY in network for Blue Cross Blue Shield of Illinois (BCBS IL) PPO. It is your responsibility to check with BCBS to determine if we are in your network. Knowing your insurance benefits is also your responsibility. Please contact your insurance company with any questions you may have regarding your coverage of *Therapeutic Services for Use of a Speech Generating* Device (92609).
2. **Non-covered services.** Please be aware that some – and perhaps all – of the services your child receives may be noncovered or not considered reasonable or necessary by BCBS IL. You must pay for these services in full at the time of visit. For example, *school consultations and attendance at IEPs will NOT be billed to insurance*. The rates for in-office and outside therapy sessions are set forth below. Rates are subject to increase on 30-day advance notification.

In-Office or Telehealth 45-Minute Therapy Session	**Outside Office 45-Minute Therapy Session**
$150	$200

3. **Co-payments and deductibles.** *All co-payments and deductibles must be paid at the time of service*. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
4. **Out of network services.** If you are not insured by BCBS IL, *payment in full is expected at each visit* unless another responsible party is guaranteeing payment (e.g., school district, trust).

In-Office or Telehealth 45-Minute Therapy Session	**Outside Office 45-Minute Therapy Session**
$150 If Payment Is Made At/Prior to Service	$200 If Payment Is Made At/Prior to Service
$165 If Billed to a Third Party	$215 If Billed to a Third Party

5. **Proof of insurance.** You must complete our intake packet before your child received services. Along with the documents in the packet, you must provide a copy of your driver's license and a copy of a valid insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

6. **Claims submission.** We will submit BCBS claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. If you do not have BCBS, you will receive a statement to submit to your insurance company to seek reimbursement.

7. **Nonpayment.** For accounts that are over three (3) months in arrears, you will be responsible for all legal and/or collection costs incurred by TALC in the pursuit of payment. These added costs include, but are not limited to, reasonable attorney's fees and court and other collection costs. In addition, your child may not receive treatment until the account is paid in full.

8. **Missed appointments.** In the event a scheduled appointment is canceled or rescheduled with less than twenty-four (24) hours prior notice to TALC, you will be responsible for a $50.00 cancelation fee. If your child arrives at an in-person session with apparent illness (e.g., fever, vomiting, diarrhea, discolored eye/nose discharge, persistent cough), your child will be sent home immediately and you will be responsible for the full session fee. In the event your child has incurred three (3) documented no-shows and/or late cancellations, your child may be subject to dismissal from services.

I hereby acknowledge receipt of this agreement, certify my understanding of the foregoing, and agree to be bound by the terms herein:

_____
Signature of Responsible Party

_____
Print Name of Responsible Party

_____
Print Name of Patient

_____
Date

CONTACT INFORMATION
The contact information of the responsible party who signed above should be filled in below.

Address:
_____
_____
_____

Telephone:
_____ (daytime)
_____ (evening)

Email Address:
_____