



# Talk Time Therapy, Inc.

## Speech & Language Services

### Fee Schedule

<b>Evaluations/Screenings</b>	<b>Regular Rate</b>	<b>Discount Rate</b>
Comprehensive Speech/Language Therapy Evaluation:	\$180	\$150
Speech Articulation Only Evaluation:	\$90	\$75
Articulation, Language, or Fluency Screening:	\$25	

<b>Therapy/Treatment Services</b>	<b>Regular Rate</b>	<b>Discount Rate</b>
1 hour Individual Therapy Session:	\$120	\$90
45 min. Individual Therapy Session:	\$90	\$75
30 min. Individual Therapy Session:	\$60	\$45
Travel Fee per Session (based on service location) (Waived for 28104, 28105, 28079, 28173, 28226, 28227, 28270, 28277)	\$5	

### Payment Information

All fees are subject to change. Your therapy rate will remain unchanged for one year.

- Discount Rate (payment by cash, check or credit card) does not include payments which will be filed with your insurance company on your behalf for reimbursement by **Talk Time Therapy, Inc** as an **OUT OF NETWORK** provider.
- Treatment fee rates (regular or discount rate) will be determined prior to beginning therapy and will remain at that rate unless change is made in advance with SLP. Parents may change their therapy rate once during the treatment period for future services if insurance benefits change.
- No refunds or credits will be issued due to insurance benefits. **Please review your benefits carefully.**
- Payment by cash, check, or credit card is due at time of service, even if insurance will be filed by **Talk Time Therapy, Inc**. If payments are received by insurance, a credit or refund for services will be issued. Most insurance benefits will be paid directly to client/subscriber from the insurance company.
- If you select the insurance filing option, **Talk Time Therapy, Inc.** will file your claims at the regular rate directly to insurance carriers as an **out of network provider**. This does not guarantee insurance payment and you are responsible for the amount not covered by insurance. Parents must also sign Insurance Agreement.
- Parents are required to provide **Talk Time Therapy, Inc.** with a credit card number to keep on file. The credit card will be charged the full session fees if a client misses an appointment or does not call by 5:00 pm the day before to cancel & schedule a make-up. If payment is not received at the time of service, the credit card will also be charged.

*I understand that if I select Discount Rate, **Talk Time Therapy, Inc.** will not submit claims on my behalf for reimbursement. I also understand that if I select Regular Rate\*\*, it does not guarantee any benefits will be paid by my insurance company and I am responsible for my fees based on this agreement at the time services are provided. I authorize **Talk Time Therapy, Inc.** to charge any fees due to missed appointments or non-payment to the credit card listed above. I understand that my fees will remain at this rate for one year from the date signed below unless my insurance coverage changes. At that time, I will sign a new rate agreement if treatment continues.*

**Required Credit Card** (see above): Card # \_\_\_\_\_ Exp \_\_\_\_\_ Code \_\_\_\_\_ Zip code \_\_\_\_\_

**I am requesting:** \_\_\_\_\_ **Discount Rate** (or) \_\_\_\_\_ **Regular Rate (Insurance Filing)\*\***

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date