



Talk Time Therapy, Inc.

Speech & Language Services

www.talktimetherapy.com

Insurance Filing Agreement

I have read and agree to the following (please initial beside each):

___ Advance payment to **Talk Time Therapy, Inc.** is required for all services being filed for insurance reimbursement.

___ **Talk Time Therapy, Inc.** files insurances as an OUT OF NETWORK provider (unless otherwise noted)

___ Benefits are usually paid directly to subscriber/client for out-of-network claims. Any payments **Talk Time Therapy, Inc.** receives from insurance will be applied to future services or refunded to client.

___ Parent is responsible to pay **Talk Time Therapy, Inc.** for any amount of the invoice not covered by insurance, including deductible or copayment.

___ Parent is responsible for determining and providing details to **Talk Time Therapy, Inc.** of out-of-network insurance benefits for speech/language therapy (**provide below****).

___ **Talk Time Therapy, Inc.** will not provide a refund or credit for fees paid if insurance does not reimburse some or all of claims or if there is any discrepancy with insurance benefits assumed or listed on this form.

___ **Talk Time Therapy, Inc.** will file insurance claims on the last day of each month.

Insurance Company: _____
Primary Cardholder: _____ Birthdate: _____
Name of Insurance Plan: _____
Group ID: _____ Policy ID: _____

****Please attach a copy of the front and back of insurance card.****

****Speech Therapy Benefits – Complete after contacting your benefits representative**:**

Evaluation: _____

Therapy: _____

___ (Initials) I give permission for **Talk Time Therapy, Inc.** to file insurance claims for speech/language services provided.

Child's Name

Child's Date of Birth

Parent Signature

Date