COLUMBUS SPEECH & HEARING
EST.1923

AGREEMENT TO PAY

Client Name: _____
DOB: _____
Insurance: _____

Thank you for choosing Columbus Speech & Hearing as your provider of services. We are a nonprofit organization that has been serving central Ohio since 1923. The client or responsible party accepts complete responsibility for payment.

☐ **We are a contracted provider of your INSURANCE:** _____

- You are expected to pay all deductibles, co-pays, co-insurance amounts and non-covered services at the time of service. We will bill your insurance for all covered services.
- You are responsible for payment in full if you failed to notify us immediately of any changes in your insurance coverage, if the claim is denied as a non-covered service, as not medically necessary or if you did not obtain a referral/authorization as required by your insurance company.

Coordination of benefits. Please note: Columbus Speech & Hearing **must** be notified of **any and all** health insurance plans you carry, even if the insurance will not cover Speech services. Failure to do this may result in you becoming responsible for payment.

We must be notified immediately of any changes to your health insurance plan(s), as your benefits may be affected and billing delayed. You must provide a copy of all new or updated health insurance cards so your insurance can be properly billed for services rendered.

You are responsible for obtaining any necessary referrals. We will attempt to obtain any required authorizations, but we may also ask you to contact your insurance company or physician to assist with this process.

Insurance providers will only pay for speech therapy services they deem **"medically necessary,"** as outlined in their medical necessity policy. Columbus Speech & Hearing will verify coverage and submit claims to your insurance company. **If your insurance company determines that the services do not fit their "medical necessity" criteria, the insurance company will deny payment for these services. You will then be responsible for paying these charges.**

A provision in the contracts between Columbus Speech & Hearing and certain participating insurance providers precludes us from billing you for services denied based on a lack of medical necessity. These insurance providers may communicate this provision to you in your Explanation of Benefits (EOB) by stating your responsibility is $0. Your signature below will waive this provision.

I have read and understand Columbus Speech & Hearing's policies as stated above. I understand that Columbus Speech & Hearing cannot guarantee payment from insurance providers for services. Therefore, if my insurance provider denies payment, I agree to be fully responsible for payment.

Client/Parent/Guardian Signature: _____ Date: _____