WORD OF MOUTH
Clinical Associates

SERVICE AGREEMENT AND PAYMENT POLICY

PLEASE READ

Child's Name: _____ **Phone:**_____

Parent(s) Name: _____

General Consent: **I understand and consent to receive for my child the services of Word of Mouth Clinical Associates. I do hereby authorize the provision of evaluation and/or treatment services with the above named child and I agree to pay in full for these services at the time of the evaluation and/or at the beginning of each month, for therapy that will occur that month, in order to receive services. I understand that I am subject to a late fee ($28) should I not pay for services by the due date posted on the invoice. I may request additional documentation or services for my child, such as, progress reports, progress conferences, and school conferences which will each incur a separate charge.** ***By initialing, I am acknowledging that I have read and agree to the above.*** _____

For Children Receiving Therapy: I understand that my child's on-site therapy services will be billed at $69 for 30 minutes / $138 an hour and that I will receive an emailed invoice via QuickBooks. I understand that my child's off-site therapy services will be billed with an additional travel fee. Payment will be due at the beginning of the month, for the hours I have reserved for my child to receive treatment for the upcoming month. I will be given an opportunity to submit via email any planned absences for that upcoming month so those sessions will not appear on the invoice. ***By initialing, I am acknowledging that I have read and agree to the above.*** _____

Unplanned Absences: **For any cancellations other than planned absences mentioned above, I understand that these missed sessions can be rescheduled if they were cancelled at least 2 hours prior to the scheduled time. I understand that makeup sessions may be scheduled on the last Friday of the month with my child's current therapist or one of the WOM speech pathologists. It is my responsibility to contact the front desk or my child's therapist to schedule the makeup session. Exceptions may be made for makeups at other times based on therapist availability or for children seen off-site. If I choose not to schedule a makeup session or do not attend a scheduled makeup session, I understand that I forfeit the opportunity to reschedule that particular session. I understand that I have 30 days to make up the cancelled session. I understand that Word of Mouth Clinical Associates does not offer refunds or credits for missed sessions that are not made up.** ***By initialing, I am acknowledging that I have read and agree to the above*** _____

5409 Maryland Way – STE 214 • BRENTWOOD, TN 37027 • 615.376.3045 •
contact@wordofmouthca.com

WORD OF MOUTH
Clinical Associates

<u>Credit card information:</u> Our office requires a credit card number to be securely kept on file. If you prefer to have the card on file electronically rather than below, please make a note. If payment has not been received by the last day of the billed month, I understand that Word of Mouth will process my credit card for the amount past due. For your convenience, there is a payment box located in the waiting area. Our office accepts cash, checks, Visa, MasterCard, and American Express. *A 2.99% processing fee will be added to each credit card transaction.

Credit/Debit card #: _____

Exp. Date: _____ CVV code: _____

Name on the Card: _____

Address for Card: _____

_____

My signature indicates that I have read and agree to all the above policies, and I assume responsibility for payment for my child's therapy services.

Parent Signature: _____

Date: _____

WHAT PAYMENT OPTION DO YOU PREFER?

- ☐ **Pay by check/cash**
- ☐ **Automatically run the credit/debit card on file**
- ☐ **Manually run a credit/debit card**

5409 Maryland Way – STE 214 • **BRENTWOOD, TN 37027 • 615.376.3045 •**
contact@wordofmouthca.com