Hues Speech Therapy Services Corp. / Shaquille Cooper M.S. CCC-SLP
250 E Sepulveda Blvd #1089 Carson, CA 90745
cooper@huestherapyservices.net
admin@huestherapyservices.net
P: 213-577-0121

Payment Policy & Fee Schedule

Thank you for choosing our private practice to serve you. We are committed to providing you with the highest quality care. Please know that the timely payment of your bill is an integral part of our service and as such, this payment policy is an agreement between you and Hues Speech Therapy Services Corp. for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family member. As a client of Hues Speech Therapy Services Corp. you are required to carefully review and sign our payment policy.

Fee Schedule

(Effective 3/28/24)

Service #1 Direct Treatment Session	**$150.00**
Service #2 Virtual Treatment Session	**$150.00**
Service #3 Six Month Re-Evaluation	**$250.00**
Service #4 Initial Comprehensive Evaluation	**$450.00**

Please read the following information carefully:

- **Direct Treatment Session includes in-person treatment of Articulation, Fluency, Language, Voice, Swallowing, and/or Social Pragmatic skills.**
- **Virtual Treatment Session includes indirect treatment of Articulation, Fluency, Language, Voice, Swallowing, and/or Social Pragmatic skills via videoconferencing platform as determined by clinician and patient.**
- **Six Month Re-Evaluations are to be conducted after 6 months of treatment following Initial Comprehensive Evaluation to determine continued need for services, revision of goals, and/or possible discharge based upon progress.**
- **Initial Comprehensive Evaluations are required for all patients to receive treatment and serve as a basis for determining area of need via standardized and informal testing.**

All therapy fees (including session fees and/or co-pays, if applicable) are due:

☐ At the time of service

We accept the following payment methods currently: cash, check, debit card/credit card, Apple Pay (Checks should be made payable to Hues Speech Therapy Services Corporation with memo for specific service).

We will provide you with an invoice outlining the services rendered and the amount charged.

Name of Client: _____ Date of Birth: _____

Please read and check all boxes to acknowledge understanding and the sign below:

☐ I understand that I am responsible for all costs / fees that any third-party payer (ex. insurance company, private school, etc.) does not cover. In the event that a third-party payer source determines that rendered therapy services are "not covered" or otherwise denied, I will be responsible for all outstanding charges. I understand that I will be billed accordingly and will be responsible for immediate payment. I also understand that Hues Speech Therapy Services Corp. will not become involved in disputes between you and your third-party source regarding uncovered charges or reasons for denial.

☐ I understand that if fees are not paid in full, treatment sessions may be postponed or cancelled until payment is received.

☐ I understand that all returned checks will be subject to a $25.00 returned check fee. Charges incurred and not paid after 30 days may be turned over to a collection agency at the client's expense. Overdue accounts may also be reported to a Credit Bureau.

☐ I understand that I am responsible for all legal and collection fees, which Hues Speech Therapy Services Corp. may incur if payment is not made in accordance with the terms and conditions herein.

☐ I understand that refunds will be issued only in instances of overpayment. All refunds will be processed within 1 week/ 7 business days after the overpayment is discovered on the client's bill or at the time the refund is requested. Refunds for payments made with a credit card will be credited back to the credit card used, all other refunds will be issued by a check. Client's who used a third-party source will not be issued a refund until full payment is received from the appropriate source.

☐ I, understand that all cancellations require 24 hours notice and that there will be a $25.00 charge for any cancellations made less than 24 hours. This charge is my sole responsibility and will not be covered by a third-party source.

☐ I, _____, (client / guardian name) understand the payment policy and the risks of not adhering to it.

_____ _____

Print Name of Client Date of Birth

_____ _____ _____

Signature of Client, Guardian or Responsible Party Relationship to Client

_____ _____

Private Practitioner / Witness Date