



Practice Policies and Health Information

By signing below, I authorize Center for Vocal Health to use or disclose my medical, financial, and all other personal health information for the purposes of providing me with treatment, collecting payment, and discussing my information with other staff to accomplish this.

Patient's Name

Signature of Patient or Legal Guardian

Date _____

I authorize Center for Vocal Health to share and discuss my information with the following person in addition to the healthcare professionals related to my care:

Name _____

Relationship_____

Policies Continued

Patient copays are due at time of service.

If you have a deductible plan, Center for Vocal Health will bill your insurance for the provided services. A portion of your deductible will be collected at the time of service.

You are responsible for all insurance copays, coinsurance, deductibles, and/or any other expenses not paid to Center for Vocal Health by your insurance.

Our office will file claims with insurance carriers with whom we have contracts; however, the guarantor is responsible for all fees, regardless of insurance coverage.

Time with our patients is very important to us. Consistent attendance at your scheduled therapy sessions is required for progress in therapy. Out of courtesy to your treating therapist, other patients, and our office staff we require a **24 business hour** notice for cancellations. Cancellations not made within this timeframe and no-show appointments will result in a **\$50 fee**.

You will be responsible for these charges as insurance companies do not pay for no-shows or late cancellations.

Accounts more than 90 days past due may be turned over to a collection agency.

I have read all of the above information and understand/agree to all provisions therein regarding responsibility for payment.

Patient/Guardian Signature _____ Date _____