Communication Cottage Therapy LLC
5000 Highway 17 Bypass South
Myrtle Beach SC 29588
PHONE: (843) 252-0033
FAX: (843) 582-0259

Private Pay
Communication Cottage Therapy, LLC

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 Communication Cottage Therapy, LLC 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 Communication Cottage Therapy, LLC you are required to carefully review and sign our payment policy.

Comprehensive Evaluations - $145 (1 hour)
Individualized ST/OT/PT Session $31.25/15 min ($125/hr)
IEP Meetings (if needed) $20.00/15 min

Please read the following information carefully:
All therapy fees (including session fees and/or co-pays, if applicable) are due: **At the time of service**

*If you have insurance and Communication Cottage Therapy LLC is in network, Communication Cottage Therapy LLC will submit the claim to your insurance.

If Communication Cottage Therapy LLC is not in network with the client's insurance (with the exception of medicaid plans) the client/family will be responsible for paying for the services at the time of service.

We accept the following payment methods at this time:
cash, check or credit/debit card
Receipts will be emailed to you if you're using a credit card.
Super bills can be made available upon request.

Please contact: Kristin Weingart, MS CCC-SLP (owner) via phone: (843) 252-0033 or e-mail:kristin@communicationcottagetherapy.com if you have any questions regarding billing.

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Please read and initial next to 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 Communication Cottage Therapy, LLC 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 canceled until payment is received.

_____ I understand that all returned checks will be subject to a $35.00 returned check fee.

_____Charges incurred and not paid after 7 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 Communication Cottage Therapy, LLC 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 7 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 have read and understand the payment policy and the risks for not adhering to it.

Signatures for Private Pay:

Client’s First Name: _____ Relationship to Child/Client: _____

Client’s Last Name: _____ Signature of Legal Guardian: _____

Client’s Date of Birth: _____ Date of Form Completion: _____

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Credit Card Authorization Form

Should you wish to choose this type of payment please complete the form in its entirety. Checks/Cash are acceptable - This form does not need to be completed. If you select a credit card as your form of payment, ST will process payment after the session is completed. .

By signing this form you give Communication Cottage Therapy LLC permission to debit your account for the amount indicated on or after the indicated date. This is permission for current and future services as outlined in this agreement, and does not provide authorization for unrelated debits or credits to your account.

Name on Card: _____

Credit Card Number: _____ **CVC**: _____ **Expiration Date:** _____

Billing Street: _____ **City**: _____ **State**: _____ **Zip**: _____

_____I authorize Communication Cottage Therapy, LLC/Kristin Weingart, MS CCC-SLP to charge fees for rendered services to the credit card provided herein.

_____I understand that the provided credit card will be charged for services rendered after each session and that I will receive a receipt sent to my email on file.

_____I authorize Communication Cottage Therapy, LLC to charge the card indicated on this authorization form according to the terms above. This payment authorization is for therapy services, for the amount invoiced by the practice and is valid for ongoing weekly and monthly services.

_____I certify that I am an authorized user of this credit card and that I WILL NOT DISPUTE the payment with my credit card company so long as the transaction corresponds to the terms indicated on this form.

Cardholder Signature: _____

Client's Name: _____ **Child's Date of Birth:** _____