Northrup & Associates

Speech Pathology
Oral Myology

6422 East Main Street (614)864-6620
Reynoldsburg, Ohio 43068 Fax: (614)864-6690

Our Financial Policy

Thank you for choosing us as your speech pathologists. We are committed to your treatment being successful. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment.

The charge per session will be determined by the time and type of service provided. A minimum of five minutes of each session is designated for parent consultation. Full payment is due at the time of service. We accept cash, check and credit cards. The adult accompanying a minor and the parents (or guardians) are responsible for full payment.

Consultations

There is a charge for consultation. The fee is determined by the length of consultation. If you need more than five minutes to speak with your therapist, please schedule an "in person" or telephone consultation time. We feel that this service is as valuable as direct intervention. We are more than happy to assist you as an advocate in meetings with other team members.

Regarding Insurance

If you have private insurance, we ask that you get reimbursement from your insurance company. We will provide you with an itemized receipt to be used in filing your insurance.

Third Party Payment

We will file claims for Board of Education (for school-age children attending private schools), and Franklin County Residential Services and Family Support Services. Payment for services not covered by Franklin County Family Resources is due within 30 days of our receipt of Family Resources reimbursement for that month.

Missed Appointments

Unless canceled at least twenty-four hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. There will be no charge for emergency situations. If three appointments are missed without notification, we will not be able to hold your weekly treatment time.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy (above). I understand and agree to this Financial Policy.

X _____ Date _____

Patient Signature or Responsible Party