Dynamic Pediatric Speech Therapy, LLC
4482 Commerce Drive, Suite 104
Buford, GA 30518
Contact@dpstllc.com
678-335-6120

Payment Policy

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 Dynamic Pediatric Speech 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 Dynamic Pediatric Speech Therapy, LLC you are required to carefully review and sign our payment policy.

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

We accept the following payment methods:

Check
Debit
Credit Card (AMEX, Discover, Visa, Mastercard, FSA)

(Checks should be made payable to):

Dynamic Pediatric Speech Therapy LLC.

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

Please read and check of 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 Dynamic Pediatric Speech Therapy, LLC will not become involved in disputes between you and your third-part 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 $ 35.00 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 Dynamic Pediatric Speech 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 2 weeks 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 a minimal of 24 hours notice and that there will be a $30 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

_____ _____ _____
Signature of Client, Guardian or Responsible Party Relationship to Client

_____ _____
Private Practitioner / Witness Date