Cincinnati Center for Improved Communication, Inc.

Services in Speech, Language, and Language-Based Learning Disorders

Agreement to Terms of Payment

I, ______________________________________, acknowledge and accept full and complete responsibility for payment for all services rendered to me by Cincinnati Center for Improved Communication, Inc.

I understand that health and accident insurance policies are an arrangement between my insurance company and myself, that all services rendered me are charged directly to me, and that I am personally responsible for payment. I agree to allow this office to release any information that is requested by my insurance company.

Further, I understand that Cincinnati Center for Improved Communication, Inc. will notify me of payments made by my insurance, as well as any responsibility regarding payment. The portion of the bill for which I am responsible will be due upon receipt. Finance charges will be assessed on patient balances not paid by the end of the month in which they are billed.

____**of**____

(Signature of Parent/Legal Guardian/Spouse) (Patient)

Date:_____________________________________

____ ____

(Address) (City/State/Zip)

____

(Telephone number)

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