Cincinnati Center for Improved Communication, Inc.

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

WAIVER

_____ ("Patient") acknowledges that Cincinnati Center for Improved Communication, Inc. (Provider) has sought pre-authorization from

_____ for the rendering of the following services:
(Name of insurance company)

_____

_____

Patient understands and acknowledges that _____ has denied
(Name of insurance company)
coverage for the above referenced service based on their determination that the service does not meet their criteria for medical appropriateness. Patient understands that if Provider were to render such service without a specific waiver, then the above named insurance company would hold Provider financially responsible, and Patient would not be responsible to pay the cost for such services.

Patient understands and acknowledges that he/she has the right to request that said service be provided notwithstanding _____ determination. If Patient
(Name of insurance company)
exercises his/her right, the Patient will be held responsible for the cost of such services.

Patient understands that the approximate cost for said services is $125.00 per hour for intervention services; $210.00 per hour for evaluation and/or consultation services and agrees to be responsible for said cost.

It is agreed that this agreement covers all charges billed after March 1, 2017.

_____ _____
(Patient Name) (Provider)

_____ _____
(Patient/Responsible Party Signature) (Date)

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