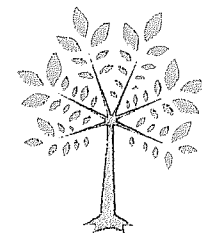


SPEECH & LANGUAGE DEVELOPMENT CENTER, LLC.

98 Lower Westfield Road
Second Floor
Holyoke, MA 01040

Phone: (413) 532-1100
Fax: (413) 532-2100
www.sldcenter.net



Payment and Insurance Acceptance Policy

If you do not have insurance coverage, payment in full is expected when services are rendered.

If you have insurance coverage, co-payments and/or co-insurance, including deductible amounts, are due when services are rendered. SLDCenter makes every effort to verify your insurance benefits before your initial visit. Your insurance company makes no guarantee of payment upon SLDCenter calling and verifying your insurance benefits. We will proceed to file all claims with your insurance company. If there are insurance issues, we will provide all requested documentation to your insurance company and re-file claims again if necessary. If, for any *reason*, your insurance company declines payment, you will be responsible for payment of all outstanding services that have been rendered.

We require a 24-hour cancellation notice. If notice is received less than 24 hours prior to your scheduled appointment time, a \$25.00 cancellation fee will be applied to your account. This fee also applies to missed appointments where no notice is given to our office. This fee must be paid at your next visit prior to seeing the therapist. Two (2) no-show appointments or three (3) cancelled appointments within a month will result in all future appointments being removed from the schedule and placed on the waiting list.

If you have any questions regarding this policy, please do not hesitate to ask.

Patient Financial Responsibility and Assignment of Benefits

I hereby authorize SLDCenter, LLC to furnish my insurance company(s) or to designated attorney, all information that said insurance company(s) or attorney may request. I hereby assign to SLDCenter, LLC all payments which I may receive from the insurance company for medical expenses relative to the service rendered, but not to exceed my indebtedness to said clinic. It is understood that payments received from the insurance company(s) over and above any charges incurred, will be applied to my account as a credit to use against future co-payments or visit charges.

I understand that I am fully responsible to SLDCenter, LLC for all charges not covered by the assignment of my insurance. Many non-covered items may include Medical Necessity, Developmental Delay, Ineligible for Coverage, or Non-Covered Benefit. The patient will be billed for any outstanding balances on their account after insurance has either rendered a payment and/or a final decision on the status of the open claim. Payment Plans are available through our billing department. In the event of nonpayment, I further understand that my account will be turned over to a collection agency for processing, which will cause irreparable damage to my credit ranking.

I have read the above and fully understand my responsibility for all treatment received.

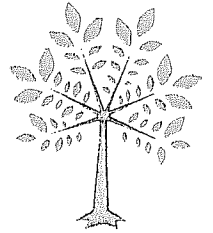
Patient or Guardian Signature

Date

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CONSENT TO TREAT

Patient: _____
(Please print full name)

Date of Birth: _____

I hereby authorize SLDcenter, LLC to perform occupational and/or speech therapy evaluation, administer therapeutic treatment as recommended in the initial evaluation and provide clinical services as deemed necessary by SLDcenter, LLC I understand that I will receive an explanation in understandable terms of the therapy recommended for the above named person, including possible side effects associated with treatment.

Insured/Guardian Signature: _____ Date: _____

RELEASE OF CONFIDENTIAL EVALUATION AND TREATMENT INFORMATION AND RECORDS TO AND FROM SLDcenter, LLC.

Notice to Patient: Your request for access to your protected health information is only applicable to the information maintained by the SLDcenter, LLC. If you would like access to your protected health information maintained by any other Health Care Provider, a separate request must be submitted to that provider.

SLDcenter, LLC has my permission to release information about the above named patient and/or make contact with the following sources by whatever means necessary. (Source examples: your family, personal physician, health specialist, hospital, school or organization.)

Name:	Phone:
Address:	Fax:
Name:	Phone:
Address:	Fax:
Name:	Phone:
Address:	Fax:
Name:	Phone:
Address:	Fax:

I, the undersigned, do hereby authorize these sources to release medical, surgical and/or psychological reports from the patient's records. This information will be used for occupational and/or speech therapy evaluation and treatment. The information should be sent to:

Speech & Language Development Center, LLC.
98 Lower Westfield Road
Second Floor
Holyoke, MA 01040

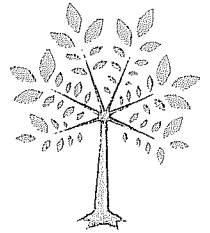
I hereby declare that I have read and fully understand all of the information above. I do hereby agree that all said information is true and correct. It is understood that I may revoke this treatment consent or release at any time by written request except to the extent that action has already been taken. I fully understand and agree to all the terms outlined above.

Insured/Guardian Signature: _____ Date _____

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Authorization for Release of Medical Information/Records

Patient Name: _____ Date of Birth: _____

I hereby authorize SLDCenter, LLC to release photocopies of my medical records and/or health information to the following individual or organization:

I further release SLDCenter, LLC from the responsibility of any effect the release of my clinical medical records may have upon myself or others both now and in the future. I personally accept all responsibility for my own distribution and interpretation of medical information contained therein and hold SLDCenter, LLC blameless for conclusions or opinions drawn without professional knowledge, assistance or review.

By state law, you must be advised that: The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS).

Signature

Guarantor Signature
(Authorized person if patient is unable to sign, or under 18 years of age)

Date

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