Miracle Farm Speech Therapy
Payment Agreement

www.miraclefarmtherapy.com

I _____ acknowledge and accept full and complete responsibility for prompt payment (within 10 days of receipt of invoice) for all services rendered to _____ by Miracle Farm Speech Therapy. I acknowledge that I have read the above provider Fee Schedule, Cancellation Policy, and Billing Policy and I agree to all.

I understand that health insurance policies and reimbursement are between myself and my health insurance company. All services rendered by Miracle Farm Speech Therapy for the benefit of the above referenced individual are charged directly to me, and I am personally responsible for payment in full to MFST within 10 days of invoice date. I understand that if my outstanding balance due to MFST reaches and/or exceeds $500.00, MFST reserves the right to withhold therapy services up to and until such balance is paid in full.

I understand that I will be responsible for all legal fees and collection fees which MFST may incur if payment is not made in accordance with the terms and conditions herein. I also understand that agreements regarding fee schedules and charges for cancelled appointments are my responsibility and not the responsibility of my health insurance company.

_____ _____

Signature of Parent/Guardian Date