Ann Arbor Speech & Language Therapy Center, LLC

creating connections

FINANCIAL RESPONSIBILITY AGREEMENT

Please initial to indicate you have read, understand, and agree with the following:

___I understand that I am financially responsible for payment of services provided to (client name) _____ by Ann Arbor Speech & Language Therapy Center, LLC.

____I understand that payment is due at the time of service.

____I understand that a $15 late fee and 5% interest charge applies if payment is not received within 30 days.

____I understand that Ann Arbor Speech & Language Therapy Center, LLC will securely keep a credit card on file to be used as a default source of payment if I am not prepared to use another form of payment (i.e., Zelle, HAS card, or personal check) at the start of the scheduled session.

____I understand that a $40 “late cancel” fee applies to appointments cancelled with less than 48-hour notice.

____I understand that a “no-show” fee of 50% of the cost of the scheduled session applies if an appointment is missed without any prior notice to cancel or reschedule.

____I understand that a $15 late fee and 5% interest charge applies if payment is not received within 30 days.

The following forms of payment are accepted:

- VISA, MasterCard, Discover, American Express
- Health Spending Account card
- Zelle
- Personal check

Failure to pay for completed services will result in cancellation of future speech-language therapy appointments and will initiate the collections process.

Party responsible for payment:

_____
Print name

_____ _____
Signature Date