Stidham
SPEECH THERAPY

P.O. Box 6425
Maryville, TN 37802
info@StidhamSpeech.com
(865) 217-6111

Payment Policy & Fee Schedule

Thank you for choosing this private practice to serve you. I am committed to providing you with the highest quality care. Please know that the timely payment of your bill is an integral part of our service and as such, this payment policy is an agreement between you and Stidham Speech Therapy, LLC for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family member. As a client of Stidham Speech Therapy, LLC you are required to carefully review and sign our payment policy.

Fee Schedule

(Effective 01/01/2026)

Speech Therapy Session (1-hour)	**$112.00**
Speech Therapy Session (45-min)	**$88.00**
Speech-Language Evaluation	**$350.00**

Please read the following information carefully:

All therapy fees (including session fees) are due:

☐ At the time of service

We accept the following payment methods at this time: cash, check, credit card

Checks should be made payable to:
Stidham Speech Therapy

We will provide you with an invoice outlining the services rendered and the amount charged.

Name of Client: _____ Date of Birth: _____

Please read and check all boxes to acknowledge understanding and the sign below:

☐ I understand that I am responsible for all costs/fees. I understand that I will be billed accordingly and will be responsible for immediate payment.

☐ I understand that if fees are not paid in full, treatment sessions may be postponed or cancelled until payment is received.

☐ I understand that all returned checks will be subject to a $25 returned check fee. Charges incurred and not paid after 30 days may be turned over to a collection agency at the client's expense. Overdue accounts may also be reported to a Credit Bureau.

☐ I understand that I am responsible for all legal and collection fees, which Stidham Speech Therapy, LLC may incur if payment is not made in accordance with the terms and conditions herein.

☐ I understand that refunds will be issued only in instances of overpayment. All refunds will be processed within 30 days after the overpayment is discovered on the client's bill or at the time the refund is requested.

☐ I, understand that all cancellations require 24 hours notice and that there will be a $50 charge for any cancellations made less than 24 hours. This charge is my responsibility.

☐ I, _____, (client/guardian name) understand the payment policy and the risks of not adhering to it.

_____ _____
Print Name of Client Date of Birth

_____ _____ _____
Signature of Client, Guardian or Responsible Party Relationship to Client

_____ _____
Private Practitioner/Witness Date

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