



Chatting Children Speech and Language Center, LLC

20604 Gordon Park Square, Suite 190

Ashburn, VA 20147

Phone: (540) 249-6221

Email: chattingchildren@gmail.com

Website: www.chattingchildren.com

Fee Schedule

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| <i>Comprehensive Language Evaluation</i> | \$600.00 |
| - Fee includes one hour of testing, full comprehensive written report, discussion with parents | |
| <i>Speech-Language screening (for articulation assessments)</i> | \$300.00 |
| -Fee includes one hour of testing, a written report and a brief conversation with the parents | |
| <i>Individual Speech-Language therapy sessions (50-minute sessions)</i> | \$140.00 |
| -Fee includes 45 minutes of one-on-one therapy with your child's trained speech-language pathologist and a 5 minute discussion with the parent in the waiting room at the end of the session. | |
| <i>Individual Reading therapy sessions (50-minute sessions)</i> | \$100.00 |
| -Fee includes 45 minutes of one-on-one reading intervention with your child's trained literacy specialist and a 5 minute discussion with the parent in the waiting room at the end of the session. | |
| <i>Group speech-language therapy sessions (50-minute sessions)</i> | \$100.00* |
| <i>School or home visits (45-minute sessions)</i> | \$135.00 |
| <i>School observations (45-minutes)</i> | \$135.00 |
| <i>Phone or office consultative services (50-minutes)</i> | \$135.00 |
| <i>School or home services (45-minutes)</i> | \$135.00 |

* If a dyad or group session becomes an individual session due to another child's cancellation, you will be billed for an individual session.

PLEASE NOTE: Payment is due at the time of services or upon receipt of invoice. If payment is not received within two weeks of receipt of invoice, your credit card will be charged for the total amount due.

I, _____, acknowledge and accept full and complete responsibility for prompt payment for all services rendered to _____ by Chatting Children Speech and Language Center. I acknowledge that I have received written explanation of the fee schedule and the cancellation policy and that I agree to both.

I understand that health insurance policies and reimbursement are between myself and the health insurance company, that all services rendered to my child are charged directly to me, and that I am personally responsible for payment to Julie K. Cotter.

Signature

Date