

# **Elizabeth I. Smith, M.A., CCC**

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## **Speech-Language Pathologist**

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Boulder, Colorado 80301  
(303) 530-9191  
www.lizsmithslp.com

### **POLICY AGREEMENT**

I/We have received, read, understand, and agree to Elizabeth I. Smith's Policy Statement and Fee Schedule (dated June 1, 2010) for her Speech-Language Pathology clients. I/We do understand that sole responsibility for payment for any and all services rendered is mine/ours. In the event that I/We default, I/we agree to pay, whether or not legal proceedings are instituted, a reasonable COLLECTION FEE, which shall be 50% of the principal balance for any debt incurred hereunder, and to pay all reasonable ATTORNEY FEES as a result of my/our default. I/We know and agree that should collection action become necessary, there will be appropriate confidential information disclosed to the collection agent.

Please return this signed form to Elizabeth I. Smith at your earliest convenience prior to the evaluation or start of therapy. Thank you.

Date: \_\_\_\_\_ Client/Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_ Client/Responsible Party: \_\_\_\_\_