Ipswich therapy centre
Helping you live, rest & play

PRIVATE CLIENT SERVICE AGREEMENT

NOTE: *A Service Agreement can be made between a Participant and a Provider or a Participant's representative and a Provider. A Participant's representative is someone close to the Participant, such as a family member or friend.*

Parties

Participant Details

Name	
Address	
Phone/ Mobile	
Email	
Representative Name **(if applicable)**	
Contact Details **(if different from above)**	
Relationship to Participant	

Provider Details

Contact name	
Company	**Ipswich Therapy Centre Pty Ltd**
Phone	**07 3812 1204**
Email	**admin@ipswichtherapycentre.com.au**
Address	**Shop 2 / 11 Ellenborough Street, Ipswich Qld 4305**

The term of the Service Agreement will commence on the nominated start date

____/__/_____ and cease on _____/__/_____.

Purpose of the Agreement

This Service Agreement is made for the purpose of providing supports to meet their goals.

The Parties agree that this Service Agreement aims to:

- Support the independence, social and economic participation of people with disabilities; and
- Enable people with a disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports.

Services Provided

The Provider agrees to provide Occupational Therapy (OT) services to the Participant that align and assist to achieve their goals.

Services may include but are not limited to:

- *Therapy*
- *Group Therapy*
- *Goal Planning*
- *Advice and support around equipment/ assistive technology including NDIS applications or sourcing equipment to include trials*
- *Assessments for Home Modifications including design, obtaining quotes and NDIS applications*
- *Travel to appointments and charged as per the current guidelines*
- *Attending meetings, phone calls, emails with Participant, Participant's Representative, other service providers, stakeholders, and significant others*
- *Preparing and providing clinical documentation including notes, assessments, or reports*
- *Researching and sourcing resources*

Provider Responsibilities

The Provider agrees to:

- Treat the Participant with courtesy and respect;
- Protect the Participant's privacy and confidential information;
- Develop a Therapy Plan in collaboration with the Participant and others as required;
- Review the provision of Therapy every 6 months with the Participant;
- Provide Therapy that meets the Participant's needs at the agreed and preferred times;
- Communicate openly and honestly and in a timely manner;
- Provide the Participant with information about managing Complaints or Disagreements;
- Listen to the Participant's feedback and resolve problems quickly;
- Provide the Participant, 24 hrs' notice where possible if the Provider has to change or cancel a scheduled appointment;

- Provide the Participant with the required notice if the Provider needs to end the Service Agreement, see “Ending this Service Agreement” for further details;
- Provide Therapy in a manner consistent with all relevant laws, including the *National Disability Insurance Scheme Act 2013* and rules, and the Australian Consumer Law; keep accurate records on the Therapy provided;
- Provide invoices and statements for the Therapy and any additional supports delivered; and
- Provide Therapy in an environment agreed upon between the Participant and the Therapist, including but not limited to site visits, home visits and in rooms appointments.

Participant/ Participant’s Representative Responsibilities

The Participant agrees to:

- Discuss with the Provider how the Participant would like Therapy to be delivered to achieve your goals and needs;
- Treat the Provider with courtesy and respect;
- Communicate openly and honestly and in a timely manner;
- Discuss with the Provider, any concerns the Participant may have regarding Therapy or supports being provided;
- Provide a minimum of 24 hrs’ notice to the Provider if the Participant is unable to keep a scheduled appointment or see “Cancellation Policy” for further details;
- Provide the Provider with the required notice if the Participant needs to end the Service Agreement, see “Ending this Service Agreement” for further details; and

Fees

The fees for face to face therapy sessions and other supports provided (non face-to-face) are set out in the attached Schedule of Supports. All prices are GST inclusive, if GST is applicable.

Payments

Full payment of the participants account is required on the day of consultation. EFTPOS facilities are available.

If the appointment is out of office, the provider will email invoices to the participant’s nominated email address. Payment must be within 7 days or prior to the next booked appointment whichever is the earlier, via direct deposit to the Providers nominated bank account or EFT. Failure to make payments, may result in future appointments being suspended.

Private Health coverage will depend on the insurance policy taken out. The insurer will need to be contacted by the Participant for information regarding coverage. Depending on the Private Health Insurance company used, payment in full may be required.

Enhanced Primary Care Plans (EPC) are accepted and must be provided prior the initial appointment. Please refer to the attached Schedule of Supports for further details on the out-of-pocket costs.

Attachment 1 – Schedule of Supports

Supports List the name of the supports	**Description of Support** List the details of the support, including scope and volume.	**Fees** List the price of the support e.g., per hour/ per session/ per unit.	**How support is provided** List how often and where e.g., in rooms, home, school, etc.
1. Providing Face-to-Face ongoing advice and support	Including but not limited to consultations in rooms, home visits, telehealth, consultations to discuss goal setting, lifestyle changes, equipment trials, major & minor modification application preparations, and Therapy sessions. All Face-to-Face visits to be negotiated at a time suitable to all Parties.	Private Fees $150.00 per hour EPC $94.90 (Gap Fee) / $55.10 (Medicare)	
2. Provide Non-Face to Face support and advice	Including but not limited to phone calls with participants and other involved parties, resourcing and problem solving, report writing, completing progress notes, clinical correspondence, planning trials for prescribed equipment, planning & organising major and minor home modifications. Consent will be obtained prior to any Third-Party involvement.	Private Fees $150.00 per hour	
3. Travel	Travel to/ from additional site. This includes any location outside of the Ipswich Therapy Centre office as agreed between the Participant and the Provider.	Travel is calculated from the Ipswich Office $150.00 per hour. There will be no charge for local metropolitan Ipswich travel i.e., less than 5 KM's drive from the office.	
TOTAL			**$**

Cancellation Policy

The Participant must provide 24 hrs notice to the Provider of cancellation or rescheduling of an appointment. The Participant agrees that the Provider may charge a cancellation fee and continuous failure to provide adequate notification, may result in the Service Agreement being terminated.

Ending this Service Agreement

Should either Party decides to end the Service Agreement they must give 1 weeks notice written notice.

If either Party seriously breaches the Service Agreement the requirement of notice will be waived.

Feedback, Complaints and Disputes

If a Participant wishes to provide feedback, make a complaint, or discuss a dispute with the Company, the Participant can email admin@ipswichtherapycentre.com.au or call the Ipswich Therapy Centre on 07 3812 1204 or complete a Feedback form. A Feedback Form can be obtained from the Administration Team or is available to download online from the Ipswich Therapy Centre website www.ipswichtherapycentre.com.au. Please return your Feedback Forms to admin@ipswichtherapycentre.com.au or post to Shop 2/ 11 Ellenborough Street, Ipswich Qld 4305.

Changes to the Service Agreement

Should the Service Agreement require any changes, then both Parties agree to discuss and review the Service Agreement. The Parties agree that any changes to the Service Agreement will be in writing, signed, and dated by all Parties on the “Amendments to the Service Agreement” section below.

Agreement signatures

The Parties agree to the terms and conditions of the Service Agreement.

Signature of *Participant/ Representative*	Name of the Participant
Date	
Signature of authorised Representative	Name of Occupational Therapist
Date	

Amendment to the Service Agreement

Details of Amendment

The Parties agree to this Amendment to the Service Agreement.

Signature of *Participant/ Representative*

Name of the Participant

Date

Signature of authorised Representative

Name of Occupational Therapist

Date

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Consent to Share Information

I understand information about myself and my disability is collected by Ipswich Therapy Centre in accordance with the Privacy Act 2009 and the information is stored securely as per Ipswich Therapy Centre's Privacy, Dignity and Confidentiality Policy. This information is confidential and only shared with others outside the organisation for my benefit and with my permission. This includes my personal information, information about support and therapy I receive, and any photographs or videos taken. I understand that in an emergency or where there is a risk to myself or others this may be done outside written permission. Some de-identified information is collected and may be shared with Government agencies.

I, _____ give Ipswich Therapy Centre permission to share information about me/ my child with the following nominated services or individuals.

Support Worker	Yes	No	NA
General Practitioner	Yes	No	NA
Government Agencies	Yes	No	NA
Other Service Providers involved in my care	Yes	No	NA
Family/ Carers (name)_____	Yes	No	NA
School/ Pre-School/ Kindy/ Child Care_____	Yes	No	NA
Other_____	Yes	No	NA

Please specify below, if there is anyone that you do not wish your care and/ or support needs to be shared with:

_____

I understand I can withdraw/ change consent at any time by informing my Occupational Therapist.

_____

Name of participant

_____ _____/_____/_____

Signature of Participant/ Representative Date _____/_____/_____