Professional Therapy Services, Inc.
1015 Oakhurst Drive, Charleston, WV 25314
Telephone: (304) 345-8101
Fax: (304) 345-7386

Thank you for choosing Professional Therapy Services, Inc. as your provider of therapy services. We offer Speech and Language, Occupational, Physical and Music Therapies. Our goal is to provide you and your family with the most current and effective treatment possible. Our office is located at 1015 Oakhurst Drive, Charleston, WV 25314 which is off of Corridor G between the Green Meadow and Lawndale Lane exits.

Financial Policy

The following information is provided to avoid any misunderstandings or disagreement concerning your responsibilities and payment for professional services provided to you. Prompt payment allows us to control cost. Outstanding accounts cost both of us time and money; therefore, all patients will be required to establish financial arrangements for payment of their account. Any and all co-payments, deductibles and coinsurance amounts are due and payable at the time of services. Any services which are deemed "non-covered" by your insurance or other payor source are your responsibility. If you do not have insurance coverage, you are required to pay at the time of service unless prior arrangements have been made with our billing department. All accounts are due and payable within 15 days of services rendered.

Please remember that your insurance coverage is an agreement between you and your insurer. It is your responsibility to communicate with your insurance regarding past due claims that are unpaid. If a problem occurs with your claim you are required to establish written financial arrangements with Professional Therapy Services, Inc. until your insurance problem is resolved. We will also contact insurance on your behalf; however, you are responsible to resolve any dispute regarding unpaid claims.

You will receive a monthly statement showing current dates of service and any balance due by you. We ask that payment be made with in 15 days of your statement date unless prior arrangements have been established.

Neglecting to remit payment after 61 days of balance due or financial arrangement will force us to limit future credit until the past due balance is settled. All patients will be required to sign a written legal agreement with our practice to alleviate any current delinquency. Please notify us immediately if you feel an error has occurred on your statement. Professional Therapy Services, Inc. firmly believes that the provider/patient relationship is based upon understanding and open communication. We have instructed our staff to make every effort available to clarify any misunderstanding or concern you may have regarding your balance. As a courtesy, our office files claims to your primary insurance on your behalf. We will also provide you with any information you need to bill any supplemental insurance you may have.

Waiver Clients: It is every client or responsible party's obligation to inform Professional Therapy Services, Inc. of any change of Waiver Agency immediately upon transfer. If PTS is not informed in a timely manner, charge for services during the delinquent period will become your responsibility since retroactive billing to Waiver Agencies is often ineffective. Initial_____

Returned Checks: There is a $15.00 charge for any check returned by the bank. If this occurs a second time, the amount of the check plus the return fee must be covered by cash, money order, certified check, MasterCard or Visa. Should this occur, personal checks will no longer be accepted and payment would then have to be made using one of the above acceptable forms of payment. Initial_____

Appointments/Cancellations/No Shows: Appointments can be made in person or by calling the office. There is no charge for appointments cancelled 24 hours in advance. AFTER 3 NO SHOWS, OR 4 CANCELLATIONS IN A FOUR WEEK PERIOD YOU WILL BE REMOVED FROM THE SCHEDULE. Over a three month period, if your attendance is less than 50%, you will be removed from the schedule. This is due to the fact that we have a waiting list to receive therapy and our therapists depend on your consistency. Your child does not receive benefits from therapy if your attendance is not regular. If you would like to resume therapy you must call the office to assure that the therapist still has an opening. Initial_____

School closing and Sickness policy: When Kanawha County Schools are delayed or closed due to weather, we will open at 10:00am. Anything prior to that hour will be cancelled. If your child is sick please do not bring them in for therapy. This includes: Fevers, flu, colds with drainage or cough and stomach problems of any nature. We have clients with compromised immune systems who cannot afford to get sick.
Initial_____

Permission for Observation: Professional Therapy Services, Inc. collaborates with area colleges and universities to provide an observation setting for training purposes. I give permission for observation of my child while receiving services at Professional Therapy Services, Inc. Initial_____

Permission to Photograph: We are requesting permission to take photographs of your child for the purpose of education and publicity. This is to include video for ST and OT students, and photographs for use in presentations to various organizations, i.e. "Buddy Walk" hosted by Down Syndrome Association of WV, and WV Autism Society activities. If you give permission please initial at the side. Initial_____

CONSENT TO TREATMENT

I voluntarily agree to receive services and authorize Professional Therapy Services, Inc. to provide such care as considered necessary or advisable.

As part of your health care, it is necessary to create, maintain and (in certain situations) share medical information concerning your health history and current health care services to carry out treatment, payment and health care operations. Our **Notice of Privacy Practices** describes how we may use and disclose your protected health information. You have the right to review our notice before signing this consent.

The terms of our notice may change. We will post a copy of the current notice in our facility. At any time you may request a copy of our current notice in effect.

You have the right to request that we restrict how protected health information about you is used or disclosed for health care treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by those restrictions to which we agree.

By signing this form, you consent to our use and disclosure of protected health information about you for health care treatment, payment and health care operations and you acknowledge that you have received a paper copy of our **Notice of Privacy Practices**. You have the right to revoke this consent, in writing, except where we have already used or disclosed your information in reliance on your prior consent.

In the event of my absence from Professional Therapy Services, Inc. property at scheduled appoints, I hereby grant PTS authority to conduct the planned treatment session of my child. Those authorized to schedule or to bring my child to appointment are listed below with their contact numbers.

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By signing this form, I the undersigned, acknowledge I have both read and understand all the terms and information contained herein. Ample opportunity has been offered to me to ask questions regarding any unclear information contained herein.

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Signature of Client or Responsible Party Date

*** Directions on back**