Treatment Plan
(Revised 4/01/23)

Directions: Information required by "solid black boxes" must be completed before submitting this Treatment Plan for approval by Scottish Rite. For **Renewals**, please submit during the last three weeks prior to the expiration of the previous Treatment Plan.

Plan Identification (by Parents/Clinician)
Initial_____; Renewal w/ no changes____; Renewal w/revisions____; Change of Clinic_____

THIS IS A TREATMENT PLAN entered into by the following named parties pursuant to a program of the Eugene F. Herman Scottish Rite Childhood Language Disorders Clinic, Inc., a Montana public benefit corporation (Scottish Rite, Rite Care), of sponsoring speech and language therapy for children, with offices at 514 14th Street West, Billings, MT 59102.

Parties (by Clinician)

__________________________ __________________________
Name of Child Child's Date of Birth

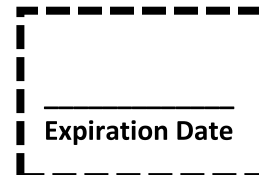
__________________________ ____
Name of Clinic/Clinician Clinician's email address Clinician's phone number

__________________________ ____
Parent to be contacted Parent's email address Parent's Phone Number

____
Parent's full address Street, City, State, Zip code

Treatment for Plan Coverage (by Clinician)
The Clinician finds that the child requires________ treatment sessions per_________________.

Term (by Scottish Rite)
INCLUSIVE DATES OF SIX-MONTH TREATMENT PLAN (By Scottish Rite)
Initial period from _____________________to _______________________.
For renewals, the most recent Treatment Plan ends ______________________.
This Treatment Plan is approved for the period beginning __________________
to and including _________________ after which it is expired.



By Parents or Clinician
NEW OR CHANGED INFORMATION
If this is a renewal Treatment Plan, attach a statement on a separate sheet of all significant changes, if any, in the financial condition of the parents or clinical needs of the child for this plan period.

ALLOCATION OF PAYMENTS FOR CLINICAL SESSIONS (By Scottish Rite)

Charge per clinical session………….... $80.00
Contribution by parents/session………$_______
Sponsorship by Scottish Rite …………… $________

Coverage of Plan: Scottish Rite is the Payor of Last Resort.

Scottish Rite does NOT pay retroactively.

Sponsorships are granted for periods when insurance coverage does not pay.

AGREEMENT (Parents & Scottish Rite)
In consideration of the Scottish Rite Sponsorship program, parents agree to:

A. Timely make the payments required by this Treatment Plan to the Clinician/Clinic.
B. Make and keep appointments scheduled with the clinician.
C. Promptly pay any relevant insurance payments received to the clinic/clinicians.
D. Timely report all available funding for this Treatment Plan to the clinic/clinician.

CONSENT TO TREATMENT AND WAIVER OF MEDICAL PRIVILEGE
Parents jointly and severally agree to the clinical speech and language treatment for the above-named child pursuant to this Treatment Plan by the named clinical provider and waive all medical privilege and rights of privacy that would otherwise attach to said medical treatment and associated record keeping as to all clinicians, clinics, clinical staff, clerical staff and members of the board of directors of the Eugene F. Herman Scottish Rite Childhood Language Disorders Clinic, Inc.

SIGNATURES

Parents

____________________________ ________ _________________________ ________
Signature Date Signature Date

Clinician

________________________________ __________________________________ _____________
Signature Clinic Date
email:____

For Eugene F. Herman Scottish Rite Childhood Language Disorders Clinic, Inc (Scottish Rite Rite Care)
by______________________________________ its_____________________, _______________
Signature Office/position Date