TERMS OF SERVICE

Child's Name: _____ **Date of Birth:** _____

Consent for Care

I have been informed that each Way to Grow (WTG) therapist is licensed and certified to provide therapeutic services according to the Plan of Care established by the therapist. I understand that it is my right and responsibility to be involved in the care of my child and that I will be informed as to the nature and purpose of any procedure. I hereby grant permission to the therapist employed by WTG to perform such examinations and therapeutic procedures professionally deemed necessary or advisable for the diagnosis and treatment of my child. I understand the recommended frequency of services, and that this frequency may change according to need.

Consent for Release of Records

It is the policy of WTG to protect all clinical records against loss, defacement, tampering, and use by unauthorized persons. I authorize WTG therapist(s) to release medical information to my child's health care provider(s), the facility of my choice, payer source, or accrediting/regulatory/consulting organizations as appropriate. I authorize the release of the Plan of Care and Discharge Summary to another health care provider upon my transfer to said provider.

Financial Policy

Effective January 1, 2026, all services (i.e. treatment sessions, evaluations, consultations, reports) will be billed at an hourly rate of $177. WTG requires a minimum of 24 hours notice to cancel a session without penalty. In the event of failure to provide such notice, WTG reserves the right to charge the full fee of $177 for the missed session. Bills will be issued at the end of each calendar month. *Clients are responsible for direct payment to WTG within 30 days of the billing date, as well as for submitting to an insurance company (1) a request for initial authorization and/or (2) claims for reimbursement.*

Initial authorization for payment generally requires:

a. Basic identifying information (provided by you)
b. Written prescription from your doctor (obtained by you with a copy forwarded to WTG)
c. Diagnosis and treatment codes (provided by WTG)
d. Copies of monthly invoices (provided by WTG)
e. Copies of daily notes (provided by WTG, as needed)

The invoice you will receive, with its standardized medical accounting system, is usually accepted by insurance companies as the provider's portion of the claim. As insurance companies' requirements vary and change frequently, you are responsible for being familiar with the stipulations of your plan. If your insurance company requests frequent and lengthy reports for therapy authorization, you will be billed at session rates if the required reports are beyond what is considered to be usual and customary for WTG to prepare for therapy purposes. You may be billed at session rates if you request that a therapist attend meetings on your behalf. For nonpayment of services, WTG reserves the right to assess a $30 per month late fee, a $50 returned check fee, as well as collection and/or attorney fees incurred by WTG.

By signing below, I acknowledge that I have read and understood the above terms and agree to them.

_____ _____

Name of parent/guardian (please print) Signature of parent/guardian

_____ _____

Relationship to child Date