ENVISION HOPE
pediatric therapy

ATTENDANCE POLICY

Regular attendance is important to achieve success in therapy and it is necessary that all appointments be kept whenever possible. Failure to keep your scheduled appointment hinders our ability to provide the best care to your child. Because of the demand for therapy services and to ensure positive outcomes, we must enforce the attendance policy.

1. Non-emergency Cancellations – Except for emergency situations, all appointments must be cancelled at least 24 hours in advance by calling or emailing the office or your therapist directly. We consider the following to be examples of NON-EMERGENCY reasons to cancel an appointment: vacations, pre-scheduled doctor appointments, family events, parties, recreational events, after school activities, lack of baby sitter, car trouble, traffic, holiday weekend, school holiday, day before or after a holiday, schedule conflict, and sibling illness. All non-emergency appointments that are not cancelled at least 24 hours in advance of the scheduled appointment will be charged a late cancellation fee. This fee is not covered by insurance or other third party payer and must be paid in full no later than your next appointment. Patient will not be seen if late cancellation fee has not been paid. Initial _____
2. Emergency: In case of emergency (sudden illness, death in family, hospitalization, emergency doctor visit), appointment must be cancelled as early as possible prior to appointment time. There is no charge for an emergency related cancelled appointment. Initial _____
3. No Show without Notification: All appointments that are missed without notification will be charged for the missed appointment. This fee is not covered by insurance or other third party payer and must be paid in full no later than your next appointment. Patient will not be seen if late cancellation fee has not been paid. Initial _____
4. Closings due to weather: If the facility decides to close due to poor weather, we will contact you. We do not necessarily close because school is closed. If we are open, and you decide to cancel due to weather conditions, you must do so at least 4 hours before your scheduled appointment to avoid a late cancellation fee. Initial _____
5. Holidays and school vacations: Our facility does <u>not</u> follow the school calendar. We are open 12 months a year and close only for the following holidays: New Year's Day, Thanksgiving Day, and Christmas Day. Unless otherwise explicitly stated by your therapist, we are open our regular hours on the days immediately before and after these holidays. Initial _____

Cancellation Fees

1st non-emergency cancellation	fee waived
2nd non-emergency cancellation	50% of session fee
3rd non-emergency cancellation	75% of session fee
4th non-emergency cancellation	100% of session fee
If late to pick up your child from treatment	$1.00 per minute

If "no shows" or cancellations reach 50% of scheduled sessions per month, treatment will be discontinued.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ THE ABOVE POLICY AND UNDERSTAND AND ACCEPT THE TERMS AND CONDITIONS.

_____ _____

Please print name of patient Date

_____ _____

Signature of parent or guardian Relationship

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General Guidelines

The following are general guidelines that will assist in creating a treatment environment that is as efficient and smooth as possible. If you have any questions, please speak with your child's therapist.

1. Please have your child dressed in clothing that is easy to move in and is OK to get dirty.
2. If you want to observe the treatment session, please discuss this with your child's therapist first. Observation is usually encouraged, but depending on the situation, it may be better if you are not present (for example, if your child has difficulty separating from you). Due to the HIPAA privacy laws, there is a specific procedure that must be followed to ensure the privacy of other clients in the treatment facility.
3. The last 5-10 minutes of the treatment session may be used for family education, discussion, and documentation. Please be present 10 minutes before the end of the scheduled session to allow for adequate discussion time. If you feel that you need additional discussion time, please schedule that time with your therapist, as this will prevent running late into the next appointment.
4. Please leave your contact information if you do not stay for the treatment session in case of any emergencies. Also, please be prompt in picking up your child when his/her session is over as we do not have the means for childcare.
5. If you are running late for an appointment, please call to let us know.
6. We do encourage rescheduling your appointment if possible, as it is essential to keep a regular schedule for the treatment to be successful.
7. When possible, give two weeks' notice of vacations and/or other times when your child cannot attend a scheduled treatment session.
8. You will be notified as far in advance as possible when your therapist is ill or otherwise unavailable. Every effort will be made to reschedule your appointment(s) so that your child will miss as little treatment as possible.
9. I agree to help keep the lobby clean and comfortable and safe for all kids by cleaning up any food brought in. I understand that it is important because some kids have food allergies. I agree to help clean up any toys left out after finished using.
10. I understand that I am responsible to provide basic needs for my child while at therapy. (i.e. diapers, bottles, snacks…)

Signature and Date

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FINANCIAL POLICY

Patient Name:_____**Date of Birth:**_____

Notice of Financial Responsibility

- All therapists are currently in-network with Blue Cross Blue Shield and we will bill them directly for you. However, any costs not covered by BCBS (deductible, co-pay, non-covered charges, etc.) are your responsibility and must be paid when claim is returned to us. Initial _____
- Fees will be collected at time of visit for all other insurances or self-pay clients. As a courtesy, we can file a claim with your insurance after payment is received. Initial _____
- You are responsible for all evaluation, treatment and consultation costs, regardless of insurance reimbursement. Payment in full is expected upon receipt of your bill or by the next scheduled appointment. Initial _____
- **Balances may not exceed $360**. If payment is not received, further therapy will be cancelled until balance is paid. Unresolved balances could negatively impact your scheduled therapy time. Initial _____
- You are responsible for payment of any and all cancellations. Please see the attendance policy for specific details. Initial _____
- **Required to put a Credit Card on file prior to evaluation.** Initial _____
- We will charge finalized balance.
    - On average it takes a week for insurance to finalize a session payment. Therefore, we will not charge your card until the payment has been finalized by insurance.

I have read the above and hereby accept all responsibility for evaluation and treatment charges incurred.

_____ _____

Responsible party and/or trustee of patient's funds Date

Consent for Care and Treatment

As the child's parent or legal guardian, I hereby consent to necessary evaluation, procedures and/or treatments prescribed by my child's therapist as considered necessary in her or his judgment. I understand that various procedures and/or treatments may be used, and I further understand that every effort will be made to ensure that my child is safe during all procedures and/or treatments, but I acknowledge that injuries or accidents may still occur. I agree that this facility shall not be liable for any injuries or accidents sustained by my child while at Envision Hope Pediatric Therapy. I understand that my child is under the care and supervision of his/her therapist.

_____ _____

Responsible party and/or trustee of patient's funds Date

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Fee Schedule

OCCUPATIONAL THERAPY INITIAL EVALUATION $300.00

- This includes time spent interviewing caregiver/family, assessing the child, scoring of standardized assessments, and written formal report

OCCUPATIONAL THERAPY TREATMENT $125.00 per 60 minute session ($31.25 per unit)

- Individual treatment sessions are usually one hour in length
- The last 10 minutes will be used for caregiver/family consultation, education and documentation

OCCUPATIONAL THERAPY PARENT CONFERENCE $125.00

- A one-hour mandatory conference after the formal evaluation to review the results of the evaluation and recommendations

SPEECH THERAPY INITIAL EVALUATION $250.00

SPEECH THERAPY SESSION $70.00

- Individual treatment sessions are usually 30 minutes in length

CONSULTATION CHARGES $35.00 per 15 minute unit

- This includes school visits, home visits, ARD's, discussion/review of re-evaluations and additional scheduled consultation in person.
- **Phone consultations** will be charged and cannot be billed through insurance.
- Travel charge for out of office visits $10.00

CANCELLATION CHARGES AND OTHER FEES

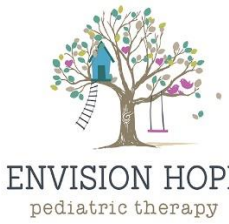
- if less than 24-hours' notice: first cancellation — No Charge
- if less than 24-hours' notice: after 1st cancellation — $65.00 OT/ $35.00 ST
- if less than 24-hours' notice: after 2nd cancellation — $110.00 OT/ $55.00 ST
- if less than 24-hours' notice: after 3rd cancellation — $125.00 OT/ $70.00 ST
- if no notice ("no show") — $125.00 OT/ $70.00 ST
- if late to pick up your child from treatment — $1.00 per minute

**If "no shows" or cancellations reach 50% of scheduled sessions per months, treatment will be discontinued.

Please acknowledge that you have read and understand the above policies by signing below.

_____ _____

Parent or Guardian Signature Date



Credit Card Payment Authorization Form

Required Prior to start of Therapy

Client Name: _____ Amount to be charged: _____

Your balance will be charged weekly to your Visa, MasterCard, American Express or Discover Card once claims have come back from insurance if applicable. You may use a HSA or FSA card but a second card must be given to cover balance when the first card is out of funds.

No shows will be charged at the time of the missed appointment.

Here's How Recurring Payments Work:

You authorize regularly scheduled charges to your credit card. You will be charged the amount of the therapy session, copay or coinsurance each week unless payment is received at time of service. A receipt for each payment will be emailed to you.

Credit Card

☐ Visa ☐ MasterCard

☐ Amex ☐ Discover

Cardholder Name _____

Account Number_____

Exp. Date _____

CVV (3-digit number on back of card) _____

Billing zip code _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Envision Hope in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

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INFORMATION AUTHORIZATION

Patient Name:_____Date of Birth:_____

Authorization to Leave a Voicemail

Please provide number(s) **ONLY IF** you approve us to leave **DETAILED** information related to the following, on your voicemail:

☐ Appointments ☐Billing ☐Test results, diagnosis, and procedures

Primary:_____ Secondary:_____

Authorization to Send an Email Message

Please provide an email address below **ONLY IF** you approve us to send **DETAILED** information related to the following to your email:

☐ Appointments ☐Billing ☐Test results, diagnosis, and procedures

Email address: _____

Authorization to Send a Text Message

Please provide a number **ONLY IF** you approve us to leave **DETAILED** text information related to appointments, billing, or treatment questions in a text message.

Phone:_____

Authorization for Medical Release

Under HIPAA requirements, we are not allowed to discuss any of your health information with anyone else without your consent. I authorize this facility to speak to the following family members or my personal representative regarding

- ☐ All medical information, including but not limited to: appointments, billing, test results, diagnosis, procedures, insurance claims, and legal matters.
- ☐ Only the following types of information:_____
- ☐ Do not disclose any information on file other than to patient on record.

The above medical information shall only be released to the following person(s):

Primary Care Physician: _____ Phone_____
Referring Physician: _____ Phone: _____
Other (Medical Specialist, School Therapist, Teacher, etc.):_____
Phone Number:_____

Others

_____Relationship:_____Phone number: _____
_____Relationship:_____Phone number: _____

By signing below, I understand and agree to all stated and filled in above; I also understand my rights are protected by the Privacy Act (HIPAA) and that I may request a copy of this Act at any time.

Name **(PRINTED)**_____

Signature_____ Date_____

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Patient Name:_____**Date of Birth:**_____

Photograph and Video Release Form

Our facility focuses on the treatment of children and on the education of future therapists. As such, we may take photographs or videos of children or family members participating in treatment. The photographs and videos may include interviews, assessments, treatment, and/or other group activities. The rights, titles, and interests of these materials belong to Envision Hope, which reserves the right to edit the material.

I, _____(please print name) consent to the taking of videos or photographs of myself or my child _____(print child's name).

I understand that these photographs or videos may be used for educational purposes, treatment purposes, and/or medical purposes in educational training programs or media publications. Specific names of children and other family members may be used in photograph or videos.

I give my permission for the use of photographs or videos for educational purposes, for news or other media for the Envision Hope website, and for training tapes.

_____ _____

Parent or Guardian Signature Date

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Client Rights

Policy: The client has the right to be informed of his or her rights. The facility will explain and comply with these rights for all clients admitted to the facility.

PROCEDURE:

A. The Client has the right to be informed of his or her rights. This Facility will protect and promote the exercise of these rights.

B. This Facility will provide the Client with a written notice of the Client's rights in advance of furnishing care to the Client or during the initial evaluation visit before the initiation of treatment.

C. The Facility will maintain documentation showing that the Facility has complied with the requirements pertaining to Client Rights.

D. The Client has the right to exercise his or her rights as a Client of this Facility.

E. The Client's family or guardian may exercise the Client's rights when the Client has been judged incompetent.

F. The Client has the right to have his or her property treated with respect.

G. The Client has the right to voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of this Facility and will not be subjected to discrimination or reprisal for doing so.

H. The Facility will investigate complaints made by a Client or the Client's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the Client's property by anyone furnishing services on behalf of the Facility, and the Facility will document both the existence of the complaint and the resolution of the complaint.

I. The Client has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished.

J. The Client has the right to participate in the planning of their care.

K. The Client has the right to confidentiality of their clinical records maintained by the Facility.

L. The Facility will advise the Client of policies and procedures regarding disclosure of clinical records.

M. The Client has the right to be advised, before care is initiated, of the extent to which payment for the Facility services may be expected from Insurance or other source, and the extent to which payment may be required from the Client.

SCHEDULING

Scheduling is done with the goal of providing the most productive therapy for our clients. We truly wish that we could accommodate everyone's scheduling preferences. We have a limited number of afterschool spots in a week which makes this one of the most challenging aspects of our job. With many years of experience, we have found that scheduling with the following factors in mind has worked for everyone:

- Younger children respond to therapy best in the earlier part of the day when they are not tired or hungry. The gym is also much quieter than the afternoon.
- Children get more out of therapy when they are with similar aged children in the environment.
- Mixing children of too wide an age span is both dangerous in the gym and not productive.

With all this in mind, we will schedule children as follows:

- Pre-kindergarten age children in the morning and up to 1:15pm
- Kindergarten age children may have 2:15pm appointments **if available**.
- 1st and 2nd graders may have 3:15pm appointments **if available**.
- 3rd graders and above may have 4:15pm and later **if available**.

This will most likely require some children be taken out of school for therapy appointments. We understand the concern of missing educational time and suggest you talk with your child's teacher about a time which would be least disruptive to their schedule. We do have early morning sessions, or you may choose to come at lunch or specials time. These sessions are excused absences, and you will be given a note from our office stating that your child received services here.

Sessions outside the clinic

On occasion, we will see children at an ABA center or school. In these cases, the child must be seen in our clinic once a week first and the second weekly session may be outside the clinic. This service is offered at our discretion and only if we feel the quality of care can be exceptional. **Initial**_____

Travel time will be charged at a rate of $35/per 15 mins and cannot be billed through insurance **Initial**_____

Scheduling changes

<u>All schedule changes must be communicated by phone or email through our office</u>. **Initial**_____

You may let your therapist know verbally or by text in addition, but we need a record of it in our office.