

Therapeutic Learning Center

Client's Name: _____ Date: _____

Evaluation Policies

I understand that I must return all requested paperwork (including this form) to the *Therapeutic Learning Center* within two weeks of the Intake Letter date, with a \$50 refundable deposit check made payable to "TLC". If the intake information is not received by that date my scheduled appointment date will be released and I will be given the next available appointment on the date that my information is received.
Initials _____

I understand that the deposit will be applied to any out of pocket expenses associated with this evaluation. If I cancel this appointment with less than 7 days notice, or fail to arrive for the scheduled appointment, the deposit cannot be refunded.
Initials _____

I understand that I am responsible for paying half of the fee for the evaluation at the time of the evaluation and half upon receipt of the written report, **unless prior written authorization has been received by the *Therapeutic Learning Center* to directly bill my insurance company or a third party.** Final payment is expected upon receipt of the written report.
Initials _____

I understand that I will receive a written report of the evaluation findings 2-4 weeks following the last evaluation session at an Evaluation Conference with the evaluating therapist. The evaluating therapist will explain the test results, answer questions, and discuss recommendations. I understand that the cost of this meeting is not reimbursed by insurance and will be billed at the standard hourly fee for the *Therapeutic Learning Center*, pro-rated for the length of the meeting.
Initials _____

I understand that this clinic is willing to provide additional calls or meetings following the evaluation if requested. I understand these additional services will be billed at the standard hourly fee for the *Therapeutic Learning Center*, in 5 minute increments.
Initials _____

I understand that if I need specific treatment objectives written as part of the evaluation, I will be charged for an additional hour of services billed at this clinic's standard hourly fee. I understand that goals and objectives at the *Therapeutic Learning Center* are typically written during the child's first treatment session.
Initials _____

I understand that a physician's referral may be required for obtaining insurance reimbursement and that I am responsible for obtaining this. When insurance coverage will be used for services, I am responsible for contacting my insurance company to determine coverage parameters and obtain any needed pre-authorization numbers.
Initials _____

I understand that in the event that any claim is rejected or denied by my health insurance company, I will become personally responsible for paying any outstanding balances for which this clinic has not been reimbursed.
Initials _____

Signature of Parent/Guardian of Client

Date

Optional Policies

I give permission for *Therapeutic Learning Center* therapists contact and discuss my child's case with all persons whose names I have provided who provide services to my child.
Initials _____