

# Therapeutic Learning Center

Client's Name: \_\_\_\_\_

## Clinic Policy Agreement

The following is a description of *Therapeutic Learning Center (TLC)* policies. Please read and indicate your agreement to abide by these policies by initialing and signing where indicated. If you have any questions about these policies, please ask a clinic representative before signing.

### Scheduling Policies

I understand that if I am a new client to this clinic using an Evaluation from another facility or am returning after an absence of more than 4 weeks, I will be required to attend an initial treatment-planning meeting with our therapist to plan the goals and objectives of treatment.

I understand that a treatment session consists of 45 minutes of direct treatment. An additional 15 minutes is used for parent consultation (5 minutes), writing treatment notes, and treatment planning (5 minutes), and setting up the clinic to tailor the environment to the client's needs for the treatment session (5 minutes).

I understand that additional time needed for consultation can be provided by ending a treatment session 5-10 minutes early, by scheduling a meeting with the therapist, by scheduling a phone consultation, or through E-Mail. I may schedule calls or meetings with my child's therapist at any time. A fee for in-depth phone consultation time (more than 5 minutes) for myself or another professional involved in my child's case will be added to my bill at the treatment rate, pro-rated for the amount of time provided. If the insurance company pays for treatment but does not authorize consultation time, this will be billed to me separately.

I understand that in order to receive maximal benefit from treatment, it is important for treatment to occur at the frequency recommended by my child's therapist. If my child misses three scheduled appointments in a row or if his/her attendance rate falls below 75% over a 12 week period I understand that my child's referring pediatrician will be notified and I may be asked to schedule a conference with my child's therapist to review his/her treatment program.

Unresolved or recurring attendance problems will result in discharge from therapy.

I understand that notification of vacations or family obligations is requested at least two weeks prior to the expected absence, to facilitate rescheduling our appointments. I understand that we may schedule make-up sessions as schedules permit.

I understand that for sessions canceled with less than 24-hour notice, a cancellation fee of \$35 will be charged but will be credited to my account if the session is made up within 14 days. I understand that if sessions are canceled with more than 24 hours notice, I will not be charged a cancellation fee; however this clinic encourages scheduling a make-up for these and all other sessions in order to ensure optimal progress.

I understand that the cancellation fee will be waived if my child is ill, but is unable to be waived due to illness of caregivers or siblings. I understand that I am encouraged to arrange for alternate transportation for my child in those circumstances.

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I understand that if we cancel with less than 2 hours notice, do not cancel and do not keep a scheduled appointment, we will be charged the full fee for the session. If our insurance company is paying for treatment they cannot be billed for the missed session, therefore I understand that I will be billed for the cost of the session at the rate reimbursed by my insurance company.

I understand that the snow day policy is as follows: the clinic is open except in cases of severe weather conditions requiring businesses to close. It is my responsibility to call the clinic to determine whether changes in the scheduled time of treatment are needed and if the opening of the clinic has been delayed. Families may cancel treatment if they do not wish to travel because of poor road conditions. I understand that snow day cancellations will not be charged and that I will not be charged a late cancellation fee.

I understand that when our therapist is ill, the clinic may not be able to provide a substitute therapist. When our therapist is on a scheduled vacation we will be given at least 2 weeks' notice and every effort will be made to provide a substitute therapist.

I understand that services will be terminated when my child has reached the maximum benefit from therapy. This will be determined by the TLC therapist in conjunction with the parent/guardians.

I have read and agree to abide by the above policies.

Initials \_\_\_\_\_

## Waiting/Waiting Room Policies

I understand that infants and young toddlers need to be accompanied by a parent during treatment; all other individuals are asked to wait in the waiting room during treatment sessions. Parent involvement in treatment sessions will be at the discretion of my child's therapist.

I understand that I am responsible for waiting with my child in the waiting room until the session begins and for monitoring my child's play in the waiting room. Accompanying siblings must be able to play quietly while waiting and may not enter treatment rooms or offices without staff permission.

I understand that due to the high incidence of food allergies within our patient population **no food or drink is allowed in the waiting areas**. Adults are permitted to bring coffee or tea in spill-proof containers; please keep them under close supervision at all times. Children are encouraged to bring water in bottles with non-spill spouts. During good weather families may use the picnic tables in the Courtyard to eat a small snack.

I understand that this clinic prefers I wait during the session so that I am available to watch parts of my child's treatment when appropriate. If I leave during a session, I understand that I am responsible for signing out, indicating the date, time, my destination, and cell phone number or method of contact so that the clinic knows my whereabouts in the event of an emergency. I understand that I am responsible for returning for my child 5 minutes before the close of the 45-

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minute treatment session. If I return more than 15 minutes after the close of the treatment session I will be charged \$1.00/minute for child-care services, payable in cash to the individual that provides supervision and care for my child. (\$15.00 minimum)

I understand that if I am unable to accompany my child to treatment appointments, my child may be escorted by a caregiver if specific arrangements are made with my child's therapist for regular direct communication with a parent.

I have read and agree to abide by the above policies.

*Initials* \_\_\_\_\_

## **Acknowledgement of Risk**

I acknowledge that there is some risk inherent in the use of the therapy equipment at this clinic, and I agree to indemnify and hold TLC harmless from any and all losses and claims for any injuries or other damages occurring to my child or myself or our belongings from the use of therapeutic equipment.

*Initials* \_\_\_\_\_

## **Financial Policies**

I have initiated services and understand that payment is due at the time that services are delivered. This includes all co-pays and co-insurance payments. Please request a receipt at time of payment; we are unable to provide printed statements of co-pays after the date of service. Payment may be made in cash, by check made out to *Therapeutic Learning Center*, MasterCard, or VISA. TLC does not accept American Express or Discover.

If I am using my health insurance coverage I understand that it is my responsibility to obtain all necessary information, along with required physician referrals prior to my child's initial treatment appointment. It is my responsibility to contact my insurance plan to find out exactly what is covered and how to obtain necessary authorizations. I understand that it is my responsibility to work with this office to obtain additional referrals for approved visits when necessary.

If the required information is not provided before the initiation of therapy, I will be obligated to pay for the services directly at the standard clinic hourly rate.

If my health insurance plan has a deductible for therapy services I understand that I am required to notify TLC prior to beginning therapy. Payment for each session is required at the time of service and the proper paperwork will be submitted to the insurance company.

If I have insurance coverage through a company other than Blue Cross/Blue Shield or Harvard Pilgrim Health Care, I understand that I may contact my insurance company about company coverage of out-of-network services, authorization procedures, and reimbursement procedures. This clinic will provide a monthly billing statement that includes all of the necessary information

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for submission (such as diagnosis and procedure codes, dates of service, and this clinic's tax identification number).

I understand that I may request a written receipt for any out of pocket expenses that may be covered by my Flexible Spending Account (co-pays, treatment equipment/supplies) at the time of service. We are unable to provide monthly or annual statements of payments made, please ask for and keep all receipts.

The *Therapeutic Learning Center* staff will assist in obtaining insurance coverage by writing reports and letters to insurance companies. Self-pay clients will be provided with 2 letters per client per year at no cost; if additional documentation is necessary a fee equal to one half of the hourly treatment rate will be charged for each report/letter.

I understand that this clinic cannot wait for payment if reimbursement is delayed. Any outstanding balance must be paid within 30 days in order to continue scheduling treatment appointments. Balances outstanding over 30 days will be charged a 5% finance charge.

I understand that any amounts not covered by my insurance, including co-pays, deductibles and non-reimbursable items (such as reports, consultation, travel, equipment and supplies) must be paid at the time the service is delivered.

I understand that if a claim submitted directly by this clinic to my insurance company is not paid within 45 days of submission, the balance becomes due immediately from me. I will be contacted by the billing coordinator to make arrangements for payment of the balance due. I have the option to authorize *Therapeutic Learning Center* to apply charges to my credit card.

I understand that it may be appropriate and necessary to meet periodically with my child's therapist to review progress, without my child present. I will be provided with a written summary of the meeting. I understand that meetings without my child present are not reimbursed by insurance coverage and will be billed at the hourly treatment rate. All other services (such as home, school, daycare, and work-site visits, and phone consultation) will be charged at the standard fee per hour for the number of hours utilized. Travel time will be billed at 50% of the standard hourly fee. If an outside agency pays for treatment but does not authorize payment for reports or meetings, I understand I will be billed for these separately.

I understand that I need to provide notification of outside meetings or consultations at least three weeks in advance to allow our therapist to prepare and to coordinate meeting dates and times. I understand that if my *Therapeutic Learning Center* therapist is unavailable, this clinic will make every effort to have another therapist attend the meeting.

I have read and agree to abide by the above policies.

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I have read the above information and understand that, as client, parent, or guardian, I am ultimately responsible for payment of services provided by the *Therapeutic Learning Center*. In the event that my insurance company or other source of payment decreases or discontinues payment for services for any reason, I will be responsible for assuming payment for past, current, and future services.

\_\_\_\_\_  
Signature/Date

## OPTIONAL POLICIES

Each of the following policies may be initialed or left blank. If you do not wish to sign any one of the following, your therapist may approach you for permission in the event that a need for any of the unsigned items occurs.

### Coordination of Care:

I give permission to have the *Therapeutic Learning Center* contact and discuss my child's case with all persons whose names I have provided as professionals working with my child or myself.

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I give permission for the *Therapeutic Learning Center* to send copies of progress reports to all referral sources whose names I have provided.

*Initials* \_\_\_\_\_

### Teaching and Research Activities:

I give permission for occupational therapy students to observe my child's therapy. I understand that I will be notified prior to each observation.

*Initials* \_\_\_\_\_

I give permission for photographs/videotapes to be taken of myself or my child for educational and/or promotional purposes. I understand that any such recordings or photographs will be reviewed by me prior to release.

*Initials* \_\_\_\_\_

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