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CLENT AGREEMENT

Welcome to Connect Pediatric Therapy. We are looking forward to working with you and your family. Please read through the following policies so you can better understand our therapy process. There is a place to initial at the end of each section. Please indicate your agreement and understanding abide by these policies by initialing where indicated. Please feel free to reach out with any questions to (402) 413-1356.

Included in this agreement are:

1. Financial Agreement
2. Cancellation Policy
3. Consent to Receive and Release Medical Information
4. Waiver of Liability
5. Clinic Expectations

If you would like to request a copy of your signed Client Agreement for your records please initial below and our office will provide a copy to you.

Initials: ______________

Send to (email or mailing address):__________________________________

COVID statement:
Effective March 15, 2020 all patients, therapists and parents/guardians will remove shoes and wear masks in the clinic. Upon entering the clinic everyone will use hand sanitizer or wash hands thoroughly. Therapists will wear a mask on home visits. We ask that families as much as possible also wear a mask. Feeding sessions will be adapted so that treatment can take place while also ensuring everyone stays safe.

Financial Agreement

Billing and Insurance

Billable services:

1. A free no-obligation 30 minute phone consultation is available prior to initiation of therapy.
2. Occupational therapy services are billed at $120 per hour
3. Occupational Therapy evaluation is $300.
    a. This will include 1 ½ hour evaluation with therapist, 30 minute parent meeting to review evaluation and an evaluation report
    b. If you choose to only have the evaluation and forgo the evaluation report and recommendations the cost is lowered to $250
4. Connect Pediatric Therapy does not wait or collect payment directly from your insurance company. Payment is due at the time it is provided. All families will receive a statement each week for services rendered through Square. Cash, checks and major credit cards are accepted. All checks should be made out to Connect Pediatric Therapy. Returned checks are subject to $25 return check fee. Additional appointments cannot be scheduled until the bill is paid.
5. Families that pay for a group of sessions ahead of time receive a 10% discount (example: 10 sessions would be $900 instead of $1000)

Credit/debit card:

For your convenience, your family has the option of placing a card on file for automatic payments. If your family would like to keep a card on file, please provide the appropriate information below. Please note that if your family does not choose to place a card on file, any payments due at the time of service must be made in person before the treatment session begins.

MasterCard: _______ Visa: _______ Discover: ______ American Express: ______

Card Number: _____________________________________ Expiration: ___________________

CSV Number: ___________

Card Holder Name: ________________________ Card Holder Signature: _____________________

Billing Address: ____

Street City State Zip

If providing credit or debit card information, please initial the following:

_____ I understand Connect Pediatric Therapy LLC will charge my card automatically for any services rendered and would like to be done after each visit

OR

_____ I would like Connect Pediatric Therapy, LLC to charge my card automatically on the first of each month regarding any due balances on my account

_____I need to set up a payment plan:

- First payment of __________will be billed day on of service (___________)
- Second payment of ____________will be billed on ___________
- Third payment of _____________ will be billed on ____________

If not providing a credit or debit card please initial the following:

_____ I understand that all private pay fees and/or out of pocket expenses are expected to be paid in-person, at the time of service. If fees are not collected at the time of service, I understand that any due balance will be billed to me on the first of each month and must be paid prior to scheduling any further appointments.

Insurance Coverage:

- *Services provided at Connect Pediatric Therapy are not guaranteed to be covered by your insurance. We will assist you in receiving reimbursement from your insurance company by providing a superbill with treatment codes upon request from family.*
- *It is the family's responsibility to file with their insurance company, and to ensure that you are being reimbursed correctly.*
- *Families can sign up to use Reimbursify. This is an app where you can scan the superbill you have been provided and file out of network claims. Our office will cover the cost of the filing fee.*
- Note that you are using "out of network benefits" with your insurance company for visits provided at Connect Pediatric Therapy. Your insurance company will assign a "reasonable and customary" amount to the charges that are billed. This is the amount the insurance company is willing to pay for each treatment code billed. Therefore, there may be a difference between the "reasonable and customary" amount that insurance will reimburse, and the amount that is billed. Please recognize that most insurance companies will expect you to meet a deductible amount before reimbursement of evaluation and treatment.

I acknowledge that I have read and understand my responsibility to pay for services. By signing this agreement I agree to the terms of this document.

Child's Name: ____

Parent/Legal Guardian Signature: _______________________________

Date: ____________________

CANCELLATION POLICY

LATE CANCELLATION, NO SHOWS, AND ASSOCIATED FEES

Connect Pediatric Therapy is committed to providing exceptional care and support to the children and families we serve. Our therapists are dedicated to using best-practice and evidence-based methods to help your child reach goals and feel successful. That means putting time and effort into planning each individual session. Please respect our dedication by committing to scheduled appointment times and the agreed-upon treatment plan. In order to ensure the most effective use of your child's therapy time, we ask that you carefully review the statements below.

PLEASE NOTE: Insurance companies DO NOT REIMBURSE for any of the fees listed in this policy.
All fees in this Cancellation Policy are parent/guardian responsibility

General Policy Statement: Connect Pediatric Therapy, LLC recommends an intensive approach to therapy, however, we understand that not all of our families can accommodate this in their busy schedules. Following the first parent meeting with your therapist, an ongoing treatment schedule will be established based upon the availability of both the therapist and your family.

Appointment Reminders: Families will receive a reminder email and/or text regarding evaluation appointment. For ongoing appointment reminders text can be sent out at parent request. Connect Pediatric Therapy asks that families follow-up by phone or email if their child's session needs to be cancelled.

Inclement Weather Policy: The clinic often follows Lincoln Public School closure, but not always. Families will receive a text to confirm whether the clinic is open or closed anytime LPS closes school.

Discharge of Services: We understand that abrupt endings to therapy may occur in the face of difficult financial situations or life events, but we do ask that families provide at least a 48-hour notice prior to their child ending, so the therapist may prepare the next session for a transition out of therapy.
Connect Pediatric Therapy reserves the right to discharge clients when:

- *Sufficient Progress* – When a child has demonstrated sufficient progress, the therapist will review the child's progress with the family and recommend a break. Treatment can be resumed at a later date if further concerns arise.
- *Financial Responsibility* – If a family is not accepting financial responsibility as outlined in our financial policy, the child's therapy may be terminated.
- Attendance – If three consecutive sessions are cancelled or marked as no-shows, the child's therapy will be immediately terminated.
- *Family Request* – Discharge of a child can be requested by the child's family. We ask that families provide 48-hours' notice if they know their child will be ending therapy.
- *Agency Discretion* – Connect Pediatric Therapy reserves the right to discharge any client at any time for any reason

Late Cancellation Fee: Your child is scheduled for a specific appointment time. Sessions cannot be extended as they are booked back to back. If you arrive later for your child's appointment you will be billed for the entire session. There is a $50 fee "no show fee" for appointments that are not canceled, or are canceled less than 8 hours before appointment time. If a family cancels the appointment due to illness the fee is waived. If the appointment is rescheduled after no-show this fee is reduced to $25.

Illness policy: If your child or someone in your family is sick with a temperature above 100 degrees, a cough or has vomited in the last 24 hours please call and cancel your appointment. As a general rule: if your child does not attend school, preschool, daycare that day-then they do not need to come to therapy either.

Please initial the following statements:

____ I understand it is my responsibility to cancel appointments at least 24 hours in advance

____ I understand that if we miss an appointment without canceling we will be charged a $50 no show fee

____ I understand that my child will lose their appointment spot if we have 3 consecutive cancellations/no shows

Connect Pediatric Therapy is happy to work with families when there are scheduling issues. If problems arise with your child's ongoing treatment schedule, please inform our staff. We are able to hold therapy spots for up to two weeks. If your child is pulled off the schedule for any reason, we will do our best to fit your child back in as soon as possible.

By signing below, I hereby understand the cancellation policy of Connect Pediatric Therapy LLC and agree to abide by it.

Child's Name:____

Parent/Legal Guardian Signature: ________________________________

Date: ______________________

Consent to Release/Receive Medical Information

It is advantageous if we are able to coordinate care for your child with other professionals. Please provide us with contact information of other professional(s) working with your child.

I agree to let Connect Pediatric Therapy share and receive information from other organizations about my child in order to best meet the needs of my child. I understand that when professionals collaborate my child receives the greatest benefit. The following individuals, organizations should be included in this release:

Medical Professionals: ____

School/daycare: ____

*Other:*____

Video and Picture Release

_______ I give permission for my child's picture/video be used by Connect Pediatric Therapy for the purpose of training other professionals

_______ I give permission for my child's picture/video to be used by Connect Pediatric Therapy for marketing/research

_______ I do NOT wish for my child's picture/video be used for any purpose other than training his/her specific clinical team

Student/Volunteer Consent

______ I give consent for students/volunteers to observe and/or participate in treatment of my child

______ I do NOT give permission for students/volunteers to observe my child's treatment

Child's name:____

Parent/Legal Guardian signature: _______________________________________

Date: ____

Waiver of Liability

For the safety of your child, Connect Pediatric Therapy recommends all parents/guardian remain in the clinic at all times during therapy sessions. This allows for quick communication and decision making in the event of an injury or emergency.

We also encourage parent/guardian to participate during sessions. It is the hard work that you do at home all week that will have a lasting impact in your child's life. You are the expert on your child, and your collaboration is very important in the success of your child's therapy.

If you choose to leave against the recommendation of Connect Pediatric Therapy, you understand that may place your child at risk for delayed medical treatment in the event of an injury.

Participation in therapy has inherent risks involved as children explore their environment in an effort to gain more information and learn. Therefore, by signing below, you hereby acknowledge that these risks have been explained to you. You further agree to waive any and all claims or theories of liability against Connect Pediatric Therapy in the event your child is injured, and a delay in treatment occurs as a result of your unavailability and/or decision to leave Connect Pediatric Therapy during your child's treatment.

You further agree that should you choose to leave during your child's therapy sessions, you will return prior to the end of the treatment session so that your child may be released to you. Appointments will last approximately 50 minutes with the last 10 minutes reserved for consultation between therapy and caregiver. If you have not returned by the end of your child's session, you will be asked to remain in the clinic for all future appointments, and may be assessed a $25 late pick up fee.

I understand the paragraphs above and have had all questions about this release answered before signing and agreeing to the above terms.

Child's name:____

Parent/Legal Guardian signature: ____

Date: ______________________