Pediatric Therapy Studio

FINANCIAL POLICY STATEMENTS

1. Payment for therapy sessions is required at the completion of each appointment with your child's therapist, with the exception of ABA clinic and home visits which are billed monthly. These must be paid by the 5th of each month. If your child is being evaluated for services, we require full payment at the time of the assessment.

2. A late fee in the amount of $50.00 will be applied to all invoices not paid within five business days.

3. Pediatric Therapy Studio will file weekly with your primary insurance company. Pediatric Therapy Studio does not guarantee any insurance coverage.

4. Regular attendance is essential for your child' s growth in therapy. Please refer to the attached Cancellation Policy.

5. The waiting area is equipped with coloring and books for your child in therapy as well as for any siblings. Please keep the waiting area reasonably quiet and assist the children with toy cleanup.

6. Families are billed for one-half hour of service for the initial treatment plan, which is written upon enrollment in therapy. Progress reports with treatment plan and goals are written every six months. Families are billed for one hour of service for these documents. lf your insurance company requests reports at more frequent intervals, there may be additional charges.

7. Snow Policy. Our office does not automatically follow any school closings. Your therapist should be contacted regarding your desire to cancel a session due to driving conditions; rescheduling when possible is appreciated.

   I have read the above policy and agree to abide by it.

   _____

   Parent/Caregiver/Guardian Printed Name:

8221 Old Courthouse Road
Suite 105
Vienna VA 22182

www.pediatrictherapystudio.com

Tel: 703-663-4808
Fax: 844-764-4499
Email: info@pediatrictherapystudio.com

Pediatric Therapy Studio

AUTHORIZATION FORM

1. I have received, read and understand your Notice of Privacy Practices. I understand that Pediatric Therapy Studio, LLC has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at its office to obtain a current copy of the Notice for Private Practices.

2. I understand that fees for services provided are due at the end of each session and that ABA monthly fees are due within five days of written invoice.

3. I understand that my invoice for services will be emailed to the address I provide unless otherwise specified.

4. I give permission for Pediatric Therapy Studio, LLC to provide evaluations, treatment, and consultative services to the below mentioned client.

5. I understand that I am granting permission for Pediatric Therapy Studio, LLC, to communicate to me about therapy sessions and my child's progress via email.

6. Each client will receive access to a parent portal whereby they can read their child's clinical notes,

   Plan of Care, assessment and progress report(s).

   Parent Email Address for Parent Portal:

   I have read the above policy and agree to abide by it.

   _____

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INSURANCE RELEASE

CHILD NAME:

DOB:

PRIMARY INSURANCE:

SECONDARY INSURANCE:

NAME OF INSURED:

DOB OF INSURED:

- Payments must be made at the time services are rendered. We accept cash, check, or major credit cards (Visa, MasterCard, and Discover).
- All appointments must be canceled 24 hours in advance. Our cancellation fee is $60.00 dollars. This CANNOT be billed to insurance.
- All no-show appointments will be charged the full therapy fee.
- Returned checks incur an additional $40.00 fee.
- Unpaid invoices will be sent to collections after 90 days.

I agree to promptly pay all charges when billed for services rendered and accept legal responsibility for any and all charges for the patient above.

_____

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INSURANCE AUTHORIZATION FORM

I hereby authorize Pediatric therapy Studio, LLC, to apply for health benefits rendered on my behalf.

I hereby certify that the information I have reported with regard to my insurance coverage is correct and further authorize release of any necessary information including medical information for this or any related claim, to the above billing, (or in case of Medicare Part B Benefits to the Social Security Administration and Health Care Financing Administration) and / or my insurance company.

I agree to update my insurance information should it change within 10 days.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier at any time in writing.

I request that payment of authorized medical benefits be made either to me or on my behalf to the above named provider for any service furnished to me or physician supplier.

_____

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APPOINTMENTS & CANCELLATION POLICY

To see progress in therapy, we must see your child! Each child has a therapy time slot that is kept only for him/her. We need to know ASAP if you need to cancel or change the time.

24-hour cancellation is preferred, but to avoid a fee, we must receive a cancellation call by 8:00 AM on the day of the scheduled session. Please leave a message on our office voicemail.

No-show appointments or those cancelled after 8:00 AM will be charged the full session rate. Make-up sessions are strongly encouraged, but the late cancellation charge will remain in place.

We love to see your child making progress, so we are strict about encouraging attendance! Therapy will be terminated following **three missed appointments** with no call to cancel. Therapy is also stopped when frequent cancellations occur without re-scheduling.

An 85% attendance rate is essential.

Consistency is a good thing! Make-up appointments are encouraged – if a make-up is held within two weeks of a cancelled session, that missed appointment will not count against your child's allowed missed sessions.

Make-ups may be workable with a different therapist. When appropriate, seeing a different OT or ST is a wonderful opportunity to gain fresh ideas and to assist your child with tolerating changes/ encouraging flexibility.

Please take note of our new Sick Policy – this has been developed to help keep all of us, therapists, families, clients, siblings, etc., healthy and available for treatment this year!

If you have decided to terminate treatment, 2 week notice is required of all patients.

For inclement weather please check our website or call the office. If nothing is noted then sessions are occurring as scheduled. Whenever possible your therapist will reschedule a missed.

I have read the above policy and agree to abide by it.

_____

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