<u>Business Policy and Financial Agreement</u>
Effective: 06/15/2016

Client Name: ____ Date of Birth: ____________

Welcome to SPOT On Therapy for Kids LLC. Thank you for choosing us as your speech-language therapy and/or physical therapy provider. Please understand that payment of your bills is considered part of your child's care. The following is a statement of our financial policy. We require a signed agreement for each child before the first appointment or consultation. If you have any questions, please ask for clarification from the clinical director before signing. Please do not direct your questions to your treating therapist(s).

POLICIES (Please initial after each number below)

1. I understand that as parent/guardian of above client, I am responsible for any and all charges incurred resulting from treatment provided by SPOT On Therapy for Kids, LLC such as, but not limited to, deductibles, co-payments, co-insurance or any non-covered services. _____________ *Initials*
2. As a service to our clients, SPOT On Therapy for Kids will file your claims with your private insurance company. We will attempt to verify client insurance benefits; however, this is not a guarantee of payment for therapy services. _____________ *initials*
3. If your insurance company denies payment for services billed, or if your insurance company has not paid a claim within 90 days of the date of service, the balance due will automatically be transferred to the parent/guardian's responsibility for payment in full. _____________ *initials*
4. Parent/guardian is responsible for informing SPOT On Therapy for Kids, LLC of any and all changes in insurance information including group policy number, identification number, phone numbers, addresses, etc. Failure to do this could result in total responsibility of charges incurred. _____________ *initials*
5. When private paying, fees for individual therapy sessions are: $120 per hour, $90 per 45 minutes, $60 per 30 minutes. Fees for evaluations are: $300 full speech and language evaluation; $175 articulation only. Fees include a written report and a consultation to review the results. _____________ *initials*
6. Invoices will be created for statement account balances due. Prompt payment of balance in full is expected within 15 days of the statement date. If payment is not received within 30 days of the statement date, treatment of client will be suspended and a 15% finance charge will be assessed. Additional 15% finance charge will be assessed for every 15 days that payment is not received.
7. If your account is past 90 days due, it may be turned over to a collection agency. If you are turned over to the collection agency, there is a $50 filing/processing fee. All collection costs and attorney fees are the parent/guardian's responsibility. Ultimately the parent/guardian is responsible for all charges incurred in our office. _____________ *initials*
8. SPOT On Therapy for Kids, LLC accepts credit/debit cards, checks and cash. There is $30 fee for returned checks. ___________ *initials*
9. <u>We require a valid credit card authorization on file and will bill your credit card for balances due.</u> ____________ *initials*
10. When billing insurance, session length is determined by our contracted rate with the insurance company and is subject to change at any time. Sessions will not be less than thirty minutes in length. _____________ *Initials*
11. Audio or video recording of sessions is not permitted without the therapists written consent. ___________ *initials*
12. I give permission for SPOT On Therapy for Kids, LLC to use pictures or video of my child on our website/social media accounts. ___________ *initials*

CANCELLATION POLICIES

1. Therapy will be most beneficial to your child with consistent attendance. A 24-hour notice is required for cancellation of therapy sessions and evaluations. SPOT On Therapy charges a $50 fee for any appointment that is not kept or not cancelled with proper 24-hour notice. In the event of sudden illness, consideration will be given. **Parents of children in childcare centers, private schools and preschools are responsible for letting the therapist know of any field trips, special events, or school holidays planned on days your child is seen for speech therapy.** _____________ *initials*
2. Therapy sessions cancelled with proper notice given will not be charged a cancellation fee. I also understand that on occasion, my child's therapist may have a conflict or illness and need to cancel or reschedule. A make-up session will be attempted when possible with one of the speech-language pathologists on staff. _____________ *initials*
3. After three cancellations (not due to illness) or no-shows within a three month period, I understand that my child is subject to discharge from therapy. There are many children and families waiting for services (especially after school hours) and we often have a waiting list during the academic school year. _____________ *Initials*

<u>COMMUNICATION:</u>

If you need to change/cancel your child's appointment, contact your child's therapist directly or (678) 644-0819.

- Liz Krupit, M.S. CCC-SLP (678) 644-0819
- Deb Notarnicola, M.S. CCC-SLP (678) 294-5812
- Barbara Earley, M. Ed CCC-SLP (404) 702-1952
- Mary Kathryn McDonald, M.A. CCC-SLP (404) 316-9740
- Megan Unger, M.A. CCC-SLP (404) 936-4090
- Sue Haviland, M.A. CCC-SLP (248) 894-2024
- Julie Deane, M. Ed CCC-SLP (678) 617-5366
- Jamie-Lee Suttles, M. Ed. CCC-SLP (706) 741-2766
- Jill Sellars, M. Ed. CCC-SLP (229) 942-8198
- Deanna Anderson, M. Ed. CCC-SLP (419) 345-8125
- Stephanie Lott, PT, DPT (973) 769-0398

____ _______________
Signature of parent/guardian Date

1. For case of communication our therapist’s do provide you with their personal cell phone numbers, but are unable to take calls while treating clients. Therapist’s will do their best to return calls as quickly as possible. It is often easier and faster to return a text than it is to return a phone call. _____________ *initials*
2. Please be respectful of the therapist’s personal time and only contact them on their personal cell phone during business hours unless it is an emergency Emails can be used at any time. _____________ *initials*
3. The therapist will contact only one parent regarding schedule changes and basic information. The parent who has the child with them at the time will be contacted and the parent who brings the child to therapy sessions will be informed of how the therapy session went It is the parent’s responsibility to communicate with each other. If there are any specific questions parents can contact the therapist. _____________ *initials*
4. If you need to change/cancel your child’s appointment, contact your child’s therapist directly. _____________ *initials*

ASSIGNMENT OF BENEFITS:

I authorize SPOT On Therapy for Kids, LLC to release any information including the diagnosis, treatment plan, evaluation report/summaries, progress notes and discharge summaries for any treatment rendered to my child during the periods of such care to third party payers.

I also authorize my insurance company to directly pay SPOT On Therapy for Kids, LLC insurance benefits otherwise payable to me. ***I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependent(s) that are not covered by my insurance carrier.***

Signature of parent/guardian ______________________ Date ____________

Child's Name ______________________ Date of Birth ____________ Relation to Child ____________

AUTHORIZATION TO RENDER THERAPY SERVICES:

I authorize the pediatric speech-language pathologists and/or pediatric physical therapist of SPOT On Therapy, LLC (Liz Krupit, M.S. CCC-SLP, Deb Notarnicola, M.S. CCC-SLP, Barbara Earley, M. Ed CCC-SLP, Mary Kathryn McDonald, M.A. CCC-SLP, Megan Unger, M.A. CCC-SLP, Sue Haviland, M.A. CCC-SLP, Julie Deane, M. Ed CCC-SLP, Jamie-Lee Suttles, M. Ed. CCC-SLP, Jill Sellars, M. Ed. CCC-SLP, Deanna Anderson, M. Ed. CCC-SLP, Stephanie Lott, PT, DPT) to provide services to my child as outlined in my child's plan of care, evaluation report, IEP or IFSP.

Signature of parent/guardian ______________________ Date ____________

Child's Name ______________________ Date of Birth ____________ Relation to Child ____________

AUTHORIZATION TO REQUEST, OBTAIN, USE OR DISCLOSE PROTECTED HEALTH INFORMATION:

I authorize SPOT On Therapy for Kids, LLC and any of its employees to request, obtain, records from previous therapy practices and /or physicians as well as release, use or disclose my Patient Health Information including records (evaluation reports, progress notes) and information regarding progress related to my child's speech-language therapy to the following person(s), entity(s), or business associates of this office either verbally or in writing; as well with our business partners, Wiles Therapy for Kids, LLC and Dr. Dawn Davis from New Day ABA.

Please list any additional professionals with whom we may correspond, such as your child's school, teacher, pediatrician, prior therapist - required if billing insurance, or other professional that you give SPOT On Therapy for Kids, LLC permission to release/obtain information from:

Name/Title: ____ Phone: ____________________ Fax: ____________________

Name/Title: ____ Phone: ____________________ Fax: ____________________

Name/Title: ____ Phone: ____________________ Fax: ____________________

Patient Health Information authorized to be disclosed (Check One):

- o I authorize the release of my complete health record.
- o I authorize the release of my complete health record with the EXEPTION of the following information: ____

This health information may be used for medical treatment, consultation, billing or claims payment or other purposes as I indicate: ____

(Choose One):

- o Effective dates for this authorization _______________ through _______________ This authorization will expire at the end of the above period.
- o All past, present and future periods.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and the revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I HAVE READ AND UNDERSTAND THE POLICIES OF SPOT ON THERAPY, LLC MY SIGNATURE CERTIFIES THAT I UNDERSTAND ALL CONTENTS AND ACCEPT THE TERMS OF THE BUSINESS POLICIES, FINANCIAL AGREEMENT, AND CANCELLATION PENALTIES OUTLINED IN THIS FORM. I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control. I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information. I understand that any violation of these items can result in the loss of services from SPOT On Therapy, LLC.

____ ____________________

Name of parent/guardian printed Date

______________________________________ ______________ ____________________

Parent/Guardian Signature Child's Date of Birth Relation to Child

I acknowledge that I have received and reviewed the HIPPA privacy policy provided by SPOT On Therapy for Kids, LLC.

____ ____________

Printed name of parent/guardian Date

______________________________________ ______________ ____________

Parent/Guardian Signature Date of Birth Relation to Child