Effective January 1st, 2018

Big Sky Pediatric Therapy

Conditions of Admission

Patient's Name:_____ DOB:_____

Authorization and Consent for Treatment

I consent to and grant permission to the employees of Big Sky Pediatric Therapy to render to my child routine clinical care including evaluations, educational services, and therapy activities/procedures during my receipt of services, and to carry out the orders of my child's physician, including consultants, associates and assistants of his/her choice. I also acknowledge that Big Sky Pediatric Therapy has not made any guarantee or warranty as to the results of any services or treatments given.

Initials _____

Authorization for Release of Information

I hereby authorize Big Sky Pediatric Therapy to furnish and release medical information to my private insurance carrier, or other third party payer, as may be required for the determination of benefits payable. Respecting my privacy and anonymity, I understand that my child's records may be reviewed for statistical purposes. I grant permission for Big Sky Pediatric Therapy to communicate all aspects of my child's care with the physician(s) whom I have identified.

I am responsible for providing signed HIPAA medical privacy documents for any professional or caregiver accompanying my child at Big Sky Pediatric Therapy.

Initials_____

Appointment, Cancellation and No Show Policy

Recurring appointments are available for patients who maintain a 75% attendance record. If you are unable to fulfill this, you may schedule on a week-to-week basis from available open appointment times.

A 24-hour notice is required for all cancellations. If a 24-hour notice is not given, a $60 fee will be charged for each occurrence. A $60 fee will also be charged for failure to show up for an appointment. After **three** cancellations with less than 24-hour notice and/or no show appointments, your child will be discharged from therapy.

**Exceptions are made on a case by case basis.

Initials_____

Credit Card on File

Big Sky Pediatric Therapy requires that we have a credit card on file for all clients. You will be notified prior to any charge of $250 or more.

Initials_____

Private Pay Rates

Private pay rates are $135 per treatment session and $325 per evaluation

Initials_____

Client Consultations

Client consultations may be scheduled for in-person or over the phone conversations to discuss your child's therapy, questions or concerns in more detail than time allows after the therapy session. You may also need to discuss home programs, write ups for school, or further discuss your child's evaluation.

Client consultations will be booked in 15 minute increments and charged respectively at our hourly self-pay rate of $135 per hour or $33.75/15 minute increments. Please schedule these consultations through our front desk. Client consultations must be paid in advance.

Initials_____

School Observations and Meetings

School observations will be a fee of $250. This will include one way drive time for the therapist, observation time in the classroom, meeting/consultation with the teacher or director if school's time permits and written recommendations provided to both school and family
School Meetings will be a fee of $150 for a 45 minute meeting with your child's teacher or ARD team to discuss and provide verbal recommendations as needed.
Please schedule these consultations and meetings through our front desk. School consultations/meetings must be paid in advance.
****Prices are subject to an increase depending on travel time and mileage for the therapist**
Initials_____

Insurance Coverage
Big Sky will verify benefits only upon initial evaluation/treatment session. Verification of benefits is not a guarantee of coverage or payment and all insurance payments are subject to medical necessity and eligibility at the time services are rendered. I understand that an office visit and specific therapy charges are incurred at each appointment. Knowledge of maximum number of visits, deductible amounts and out of pocket maximums are your responsibility. It is your responsibility to update us on any changes made to your insurance.

Co-pays, deductibles and coinsurance are due at the time of service. In the event that you carry an account balance 60 days from your initial statement, you will be assessed a late fee of 15% of the balance (minimum of $20) monthly until paid in full. If the balance is not paid upon the 120th day, your account will be sent to a third party collection agency. If you are unable to provide Big Sky Pediatric Therapy with your current insurance information prior to your child's appointment, payment will be due in full for that day's visit. **If your insurance delays payment and the balance is past 60 days, the balance is your responsibility and is due immediately.**

Big Sky endeavors to file insurance claims promptly and accurately to ensure full payment by your insurance company. However, a credit card (Visa, MasterCard or AMEX) is required on file so that any outstanding balance, after insurance payment is received, can be rectified immediately. You will be contacted if the charge is over $250.

Questions regarding insurance claims or payments should only be directed to the insurance team of Big Sky Pediatric Therapy and not to treating therapists.
Initials_____

Children in waiting room
For the safety of your child, children are never to be left alone in the waiting room or enter Big Sky unescorted.
If your child is left unattended, you will be charged $1.00 per minute for a staff member to supervise your child.
Initials_____

Late Arrival to Therapy Session
Please arrive promptly for your child's therapy session. If you are not able to arrive within 15 minutes of the start time, you will be required to reschedule the appointment or pay the "Less than 24 hr cancellation" fee.
Initials_____

Late Pick Up Policy
We encourage parents to remain in the waiting room or observe during your child's therapy time. If you do need to leave the premises, please be available for your child at least 15 minutes before the end of your child's appointment to discuss the session and any home exercises for continued progress toward goals. If your child would otherwise be left unattended outside of their appointment time, you will be charged $1.00 per minute for a staff member to supervise your child.
Initials_____

Appointment Hold on Schedule
If you would like to keep your timeslot on the schedule, while being away, we will hold your spots for 2 weeks without charge. If you will be away for over 2 weeks, you have the option to hold your spot for a fee of $30 per appointment. If you do not wish to pay a fee and instead give up your appointment time, we will do our best to find another time that works for you when you are able to return.
Initials_____

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Certification

I certify that any and all information given by me to Big Sky Pediatric Therapy is correct, to the best of my knowledge. I agree that a copy of this form shall be valid as the original and will not expire. I have read this form (or it has been read to me) and I certify and understand and agree to all of its conditions.

_____	_____	_____
Parent/Guardian Signature	Relationship to Patient	Date