

Effective January 1st, 2020

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 \$30 fee will be charged for each occurrence.

A \$60 fee will be charged for failure to provide any notification prior to the scheduled appointment time.

After **three** cancellations with less than 24-hour notice and/or no-show appointments, your child will be removed from their ongoing appointment time.

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 \$250.00 or more.

Initials _____

Private Pay Rates

Private pay rates are \$108.75 per treatment session and \$360.00 per evaluation. For patients with insurance, Big Sky will discount any "non-covered services" to the private pay rate in lieu of the higher billed rate.

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 \$145 per hour or \$36.25/15 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 \$250.00. 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 \$150.00 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 Pediatric Therapy 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 Pediatric Therapy 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 \$250.00.

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 12 minutes of the start time, you will be required to reschedule the appointment or pay the "Less than 24-hour 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 10 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 \$30.00 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 _____

Appointment Hold for Medicaid

If your child becomes ineligible for Medicaid coverage during the course of treatment, we will hold your spot for 2 weeks without charge. If you would like to hold the spot for a longer time, you have the option to hold your spot for a fee of \$30.00 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 suitable time once your child has insurance coverage again.

Initials _____

Policy for Separated or Divorced Parents

Big Sky Pediatric Therapy cannot be party to or be involved in any legal issues including separation, divorce or custody agreements. The therapists, administration staff and owner of Big Sky will strive to stay neutral and not participate in disagreements over the phone or in the office.

Either parent or legal guardian can schedule an appointment for their child, be present for the visit, and/or obtain a copy of the visit summary. Unless there is a court order in the child’s record that restricts a parent’s rights, please do not ask us to limit the other parent’s involvement in your child’s care.

Co-pays, deductibles and coinsurance are due at the time of service regardless of which parent is responsible for medical coverage. We are not a party to your divorce agreement. We will collect payment due from the parent who brings the child to the visit. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent’s responsibility to collect from the other parent.

We will not be involved in any disputes regarding named individuals on your child(ren)’s consent to treat form. Both parents/legal guardians can see who is named on each. We will not comply with requests to eliminate names on the other’s form, unless instructed by the Court. Please refer these requests to your attorney. We will not call the other parent for consent prior to treatment or inform the other parent whenever visits are scheduled.

Should any issues between parents become disruptive, we reserve the right to discharge your family from further treatment.

By signing this form, you agree to honor the above policy and understand that breaking this agreement may result in the discharge of your family from the practice.

Initials _____

Email Communication

Big Sky Pediatric Therapy may use email to communicate with parents/guardians regarding your child’s medical records; including but not limited to, discipline specific reports, progress notes, home programs, plan of care, feedback, insurance information, billing statements and scheduled appointment information. If you do not wish to communicate via email, please alert our front desk.

Initials _____

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