SENSORY KIDS CLIENT AGREEMENT

Thank you for choosing Sensory KIDS. We are looking forward to working with you and your child! In order to help you understand our therapy process, please review the following policies and let us know if you have any questions.

The following is a description of Sensory KIDS, LLC's policies. Please read and indicate your agreement to abide by these policies by initialing and signing where indicated.

- It is very important for you to play an active role in your child's therapy. For this reason, you are welcome and encouraged to observe or participate in treatment sessions. If it is necessary for your child's sibling/s to accompany you, you will be expected to stay with them in the waiting area or one of our observation rooms, unless they are asked to participate in the therapy session by the therapist.
  _____initials
- Children often have difficulty with transitions. For this reason, we ask that parents/guardians/caregivers make payments and take care of scheduling needs at the beginning of the session. Sessions will be 50 minutes long, allowing time to support the child in transitioning out of the clinic. Longer conversations about therapy should be saved for designated parent education meetings, or parents may email the therapist at any time. (Consultation Policy will be issued at first parent meeting or first therapy session).
  _____initials
- To take full advantage of the 50-minute parent education sessions, parents and therapist must be able to speak freely. Children are not allowed in the parent education sessions and cannot be left unsupervised during these sessions.
  _____initials
- Children who are using iLs (listening therapy) should not eat, suck on candy or cough drops, or chew gum in session. The jaw movement interferes with the muscles in the inner ear and thus conflicts with the work the ears are doing while listening. Your child may bring a water bottle to sip from if they wish.
  _____initials
- I understand that cell phones are disruptive and are not to be used in the clinic during sessions.
  _____initials
- I am aware that siblings are not allowed in the gym unless my child's therapist has planned to include them in a session.
  _____initials

- Our privacy policy requires that only Sensory KIDS staff are allowed in the offices, unless escorted by a staff member. I understand that this policy is in place to protect my privacy and the privacy of other Sensory KIDS clients.
  _____initials
- I understand that commitment to the treatment program is very important. Inconsistent therapy will not be effective. If 3 consecutive appointments are missed/cancelled, it will result in the termination of our scheduled treatment times.
  _____initials
- We recommend that a parent/guardian be present for the child's sessions. Parents who leave must provide contact information/cell phone number and return 10 minutes before the end of the session, so your child's therapist can talk with you. A $25 late pick-up fee will be charge for every 10 minutes over your child's therapy time.
  _____initials
- I understand that if I arrive later than 15 minutes of the session start time that my appointment will be cancelled and I will be charged a $50 late arrival fee.
  _____initials
- If your child is sick with a temperature of 100° or more, a cough, or has vomited in the past 24 hours, please call and cancel your child's appointment. Your child will not benefit from therapy if s/he is this ill. I understand that cancellations due to illness will not be charged a cancellation fee.
  _____initials
- I understand that feeding sessions require a significant amount of time and money for planning and preparations. I understand that I will be charged a one-time fee of $50 that will cover food costs for all of my child's feeding sessions. (Please allow at least 48 hours notice if you know that you will have to miss a feeding appointment).
  _____initials
- I understand that for sessions cancelled with less than 24-hours' notice, unless due to illness, a cancellation fee of $50.00 will be charged and is billed directly to me. I understand that if sessions are cancelled with more than 24 hours notice, I will not be charged a cancellation fee.
  _____initials
- I understand that if we do not cancel and do not keep a scheduled appointment (NO SHOW), we will be charged $88.00. I also understand that 3 no shows will result in the termination of our scheduled treatment times.
  _____initials
- I understand that the inclement weather policy is as follows: the clinic is open except in cases of severe conditions requiring businesses to close. It is my responsibility to call the clinic to determine whether changes in the scheduled time of treatment are needed and if the opening of the clinic is delayed. Families may cancel treatment if they do not wish to travel because of inclement weather. I understand that if the clinic is open, a $50.00 cancellation fee will be charged for missed appointments.
  _____initials

FINANCIAL POLICIES

1. I understand that payment is due at the time of service. This includes full payment for self-pay, co-pays, and co-insurance.
_____initials

2. Sensory KIDS will bill my insurance (when applicable) and is a preferred provider for the following plans: Aetna, Moda Health, Tricare, Cigna, Health Share Care Oregon, and Regence BCBS of Oregon. Sensory KIDS will bill other insurance plans as an out of network provider.
_____initials

3. I understand that it is my sole responsibility and not that of Sensory KIDS, to financially cover payment for the evaluation service if an evaluation has already been rendered at another facility and submitted to insurance for payment within a given period as insurance will only cover one evaluation per set number of days.
_____initials

4. As a courtesy to you, Sensory KIDS's billing team will provide an *estimate* of your insurance benefits. This information is <u>not a guarantee of payment</u> and all services are subject to the terms and agreement of your plan. As this is only an estimate of benefits, we strongly recommend calling your insurance plan with any questions you may have. I understand that I am responsible for clarifying the terms and conditions of my insurance plan.
_____initials

5. I understand that as a courtesy, Sensory KIDS will assist with tracking visit counts. However, it is my responsibility to track the number of visits that have been used in accordance with how many visits my insurance company has approved. I also understand that the number of sessions approved by the insurance company is NOT related to the recommendation of my child's therapist. If therapy sessions exceed the number of allowable/approved number of visits, I will take full responsibility for payment of visits not covered by my insurance company.
_____initials

6. I understand that it is my responsibility to inform Sensory KIDS of any changes to my insurance plan and/or coverage including, terminated/lapsed coverage and/or policy/plan changes or modifications. I accept full financial responsibility for any sessions not covered by insurance.
_____initials

7. I understand that Sensory KIDS, LLC may bill my insurance company only when the proper insurance information is on record. The following information is required in many cases:
a. A doctor's referral from primary-care physician
b. Copy of insurance card
c. Pre-authorization from my insurance company
d. Legal name and date of birth for primary insured and child
_____initials

8. If my account becomes overdue by 30 days, I understand that Sensory KIDS, LLC, will discontinue therapy until payment is made. I understand that our treatment slot will be maintained for only one week following temporary discontinuation.
_____initials

9. If my account becomes overdue by 30 days, I will receive a phone call from MBA Medical Billing requesting payment. At this time, I may negotiate a payment plan. If my payment is not received within 45 days past due, my credit card will be charged for the full balance of my account.
_____initials

10. If I should pay my account balance with a personal check and the check should not clear, due to insufficient funds, I agree to resubmit payment to Sensory KIDS and will cover all service charges associated with the bounced check.
_____initials

11. Sensory KIDS requires a credit card on file. If my account accumulates an overdue balance, my credit card will be charged (please see number 9 below for details).

___MasterCard ___Visa ___Discover

Card number: _____ Expiration date: _____
CSV number: _____

Cardholder Name: _____

I, _____, authorize Sensory KIDS to bill my credit card as described above in this Client Agreement, or as determined by alternate agreement reached by both parties. Cardholder acknowledges receipt of services and agrees to perform the obligations set forth in the Cardholder's agreement with the Issuer.

_____ _____
Cardholder's Signature Date

12. I have read the above information and understand that, as a client, parent, or guardian, I am ultimately responsible for payment of all services provided by Sensory KIDS, LLC. In the event that my insurance company (or other source of payment) refuses payment for services for any reason, I will be responsible for assuming payment for past, current, and future services.
_____initials

COMMUNICATION

13. Sensory KIDS therapists, staff, and billing team utilize email for communication about treatment, billing, and other Sensory KIDS business. I consent to communication via email.
_____initials

14. I understand that a therapy session includes the last 5-10 minutes for documentation of my child's progress during therapy and may be used for short consultations with my therapist. If I need more consult time I understand that I must let the therapist know in advance, so she/he can

prepare accordingly. I am aware that consultation time over 10 minutes will be billed at the hourly rate as an out-of-pocket expense and is not billable to insurance.
_____initials

15. I understand that discussions about my child are often not appropriate to have with my child present. In this case, or when a short consultation is not sufficient, I may schedule adult-only meetings with my child's therapist.
_____initials

16. I understand that email should be used for quick updates regarding my child's therapy. Email communication will be kept brief, and emails taking over 10 minutes will be billed in 15-minute increments at the hourly therapy rate. Should a more comprehensive conversation be needed, I understand that I will need to connect with the front desk receptionist and schedule a parent education meeting with my child's therapist.
_____initials

17. I understand that there is a fee associated with written reports, and that therapists require advanced notice to schedule time for report write-up. It may take up to 30 days to receive a progress report or re-evaluation report.
_____initials

ACKNOWLEDGEMENT OF RISK

18. I acknowledge that there is some risk inherent in the use of the therapy equipment at this clinic, and I agree to indemnify and hold Sensory KIDS, LLC, harmless from any and all losses and claims for any injuries or other damages occurring to myself or my child or our belongings from the use of therapeutic equipment.
_____initials

19. I acknowledge that siblings are not allowed in treatment areas, unless explicitly invited by a therapist. I will not allow siblings into treatment spaces, as this poses a risk to safety for children and liability for Sensory KIDS, LLC.
_____initials

20. I understand that services will be terminated when the client has received the maximum benefit from therapy. This will be determined by the Sensory KIDS, LLC therapist in conjunction with the client, parent, physician, and/or teachers.
_____initials

TEACHING AND RESEARCH ACTIVITIES

21. I understand that Sensory KIDS is a teaching facility. Occupational therapy masters or doctorate level students who complete internships at Sensory KIDS frequently observe and take part in therapy sessions. This participation will take place with direct supervision of my child's therapist. I give permission for occupational therapy students to participate in my child's therapy.
_____initials

22. I give permission for photographs/videotapes to be taken of my child for educational purposes. I understand that any such recordings or photographs will be reviewed by me prior to release.
_____initials

23. I understand that Sensory KIDS is a facility that values learning and education. Volunteers are frequently on site to support therapists. Volunteers are trained to adhere to clinic policies and federal privacy guidelines. Volunteers may observe sessions, as deemed appropriate by occupational therapists.
_____initials

I have read and agree to abide by the above policies.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE

PLEASE KEEP FOR YOUR RECORDS

Private Pay Costs and Applicable Fees

Sensory KIDS is committed to providing the highest quality care at a fair and reasonable cost. For clients who choose to pay the out-of-pocket rate for our services, the following fees will apply. All fees will be collected at the time of service and are subject to change based on the contractual agreements held by Sensory KIDS.

Sensory KIDS is able to extend the following discounts based on payment type. Please note that the fees listed in the chart below are representative of rates *before* applying discounts.

- 5% Discount on payments, paid in full at time of service, via credit/debit
- 10% Discount on payments, paid in full at time of service, via cash or check

Evaluations	
• **Comprehensive Evaluation (60-90 minutes)** Includes standardized testing, clinical observation, written summary, and 1-hour parent education meeting	• $500
• **Re-Evaluation (60 minutes)** Includes review of recent external evaluation, clinical observations, and written summary	• $285
• **Written Comprehensive Evaluation Report or Detailed Progress Report**	• $90
Treatment	
• **OT Session (50 minutes)** With or without listening therapy	• $165
Meetings/Consultations	
• **Parent Education Meetings (60 minutes)** Meetings scheduled to review evaluation reports, set goals, discuss progress, and recommend home programs (the parent meeting following an initial evaluation is included in the evaluation cost listed above)	• $165
• **Phone Consultations** After complimentary 15-minute mark	• $33 for every 15 minutes
Additional Fees	
• **No Show**	• $88
• **Late Cancellation** Appointments not cancelled within 24-hours notice (with the exception of illness) or families who arrive 15-minutes into their child's appointment time	• $50
• **Late Pick Up Fee**	• $25 for every 10 minutes
• **Email Communication/Documentation Requests/Legal Consultation** Emails taking over 10 minutes, client requests for additional documentation, court appearance with legal counsel	• Billed at the hourly rate in 15-minute increments
• **School Visits/Observation** If school is more than 5 miles from the clinic	• $50/ $165 for each additional hour of observation
• **Feeding Charge** One-time fee	• $50