Pediatric Therapy Studio

CLIENT AGREEMENT

I _____ understand that my signature below indicates that I have read and agree to the conditions set forth in the handbook. It does not indicate that I am waiving any of my rights.

I understand I can choose to discuss my concerns with Pediatric Therapy Studio, LLC, before commencing services for formal applied behavior analysis. I understand that any of the points mentioned in the handbook can be discussed and may be open to change, on a case-by-case basis. If at any time during the therapeutic treatment I have questions about any of the subjects discussed in this handbook, I can talk with my child's Clinical Supervisor and Pediatric Therapy Studio, LLC will do its best to provide concise answers.

I understand that after applied behavior analysis begins I have the right to withdraw my consent to continue services at any time, for any reason. However, I will make every effort to discuss my concern with Pediatric Therapy Studio, LLC before ending behavior therapy services.

I understand that Pediatric Therapy Studio, LLC has made no specific promises to me about the results of treatment or training, the effectiveness of the procedures used by this company or the number of sessions necessary for behavior analysis to be effective.

I have read, or have had read to me, the topics and points in this handbook. I discussed those points I did not understand, and have had my questions, if any, fully answered. I agree to act according to the points covered in this handbook.

I hereby agree to applied behavior analysis services with Pediatric Therapy Studio, LLC and to cooperate fully to the best of my ability, as shown here.

I understand that Pediatric Therapy Studio, LLC may sever this relationship at any time by myself or should services no longer be of benefit to the client, or for any other valid reasoning, given the minimum of two weeks prior notice. I understand that if I sever this relationship prior to the two weeks notice, I will be responsible for fees incurred for those two weeks of scheduled sessions due to work lost.

PRINTED NAME:_____
RELATIONSHIP:_____
SIGNATURE:_____
DATE:_____

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

PROGRAM GUIDELINES

Your cooperation on the following is greatly appreciated to assist us in working with your child.

1. Your child should be dressed and fed prior to therapist arrival or arrival at the clinic unless these skills are being addressed in the program.

2. In-home sessions: A parent or responsible adult must be in the home when therapy is being provided.

3. In-home sessions: The area being used for therapy must be a comfortable temperature, well lit and relatively free of distractions. It is important that we are able to conduct the session in a professional manner with materials ready and limited access to competing reinforcer (i.e. toys that are not used during the therapy session).

4. In-home sessions: Please do not use therapy materials and reinforcers outside of therapy time. If you would like to run programing with your child, please let us know and we will gladly teach you how to run the programs and take data.

5. Clinic sessions: Please arrive on time to drop off and pick up your child. If you need time to talk with your therapist or supervisor, please let us know in advance, so we can be prepared and possibly help prepare your child for the extra wait time.

6. The therapist is NOT allowed to take a client in their (parents/guardians) automobile.

7. The therapist will wait 15 minutes if child is not present at the scheduled therapy time and then is allowed to leave. The child will be considered absent . You will be charged for the session and this is not billable to insurance. If more than 20% of scheduled sessions are missed, within a 3-month period, we reserve the right to dis-enroll the child from the program and offer the slot to someone else.

8. If your family is planning a extended vacation (more than two weeks), please inform the therapist and supervision. We will continue to reserve the spot for your child, but cannot guarantee that therapy slot. Additionally, we will continue to reserve the spot for your child, but cannot guarantee that your child will work with the same therapist. Our therapists are only paid for services rendered.

9. Please do not call the therapists before 8 am and not after 8 pm.

10. Parents should contact the clinic 24 hours prior to the appointment if the parent knows they are going to cancel a session

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PROGRAM GUIDELINES CON'T

11. Sickness: Please notify the therapist, as much in advance as possible, at least the night, before the scheduled session if you know that your child (or other children in your home) will not be able to participate in the program the next day due to illness.

Therapy will resume as soon as the child's doctor clears him/her of being contagious or the remedy is completed. If a therapist arrives at the home and the child is sick, the therapist will not be able to work with your child if they have the following:

- Temperature above 100
- Mumps
- Pin Worm
- Communicable Disease
- Chicken Pox
- COVID-19
- Strep Throat
- Foot/Mouth Disease
- Measles
- Lice
- Vomit
- Diarrhea
- Rash
- Pink Eye

12. The therapist will call the family if they are going to be arriving more then 5 minutes late.

13. If parent or therapist cancels a session, you may try to reschedule an appointment for a different day or time if it is available.

14.Wait List: If another client cancels their appointment, we will contact clients on the waiting list on a first come, first call basis.

15. All rescheduled appointments are scheduled through the clinic. Families and therapist cannot change appointment times without an agreement with the family.

INITIAL PAGE: _____

Pediatric Therapy Studio

PROGRAM GUIDELINES CON'T

16. Parents and staff should be respectful and courteous to each other. Open communication between parents and staff is essential to the establishment of a successful program for the child. All communication must be done in a courteous and respectful manner. If there are any problems or concerns, please contact the BCBA Supervisor or the Clinical Director immediately.

17. Parents are encouraged to share with behavior technicians any information that may be helpful in getting to know their child and will enable them to work successfully with the child.

18. Please understand that all information shared is HIPPA protected, it is essential that every Pediatric Therapy Studio technician respects and maintains each client's right to confidentiality regarding his or her treatment and all personal information. All HIPPA laws apply. Please do not ask about another clients program or treatment, as this information will not be discussed and could possibly lead to the dismissal of your child from the program.

19. Periodic videotaping of sessions may be helpful in assessing the progress of the child. Prior to a videotaping session, permission must be obtained by all parties involved and can be terminated at any time. Additionally, parents may request a copy of the taped session on a medium provided by them.

20. Parents must sign each therapist's timesheet to confirm the number of service hours provided at the end of each session. Parents are responsible for ensuring accuracy of hours.

21. No therapy for siblings. Pediatric Therapy Studio, LLC technicians are not obligated to work with siblings. If a therapist feels a sibling can be used as a participant in a session, it is at their discretion. I

22. The first 5 minutes of in-home session is used to prepare for the session and set up the environment. If you need a few minutes to talk with the therapist before the session, please let the therapist know, but be aware that your child may be anxious to begin "playing" with the therapist.

23.The last 15 minutes of in-home and school sessions are for the therapist to graph and record data regarding the session. Please allow this time without the child. Therapist will share highlights of the session and request your initials on the session notes sheet.

INITIAL PAGE: _____

PROGRAM GUIDELINES CON'T

24. During supervision session, the Clinical Supervisor and therapist will review the child's treatment book to updated and incorporate any recommended changes. If parents would like to discuss any issues, please advise the therapist at the beginning of the therapy session. Any time taken for data entry and graphing, log book update, or to discuss program issues shall be considered billable time.

25. Supervision is required at a minimum of 2 hours every month and a maximum of 4 hours per month. Pediatric Therapy Studio, LLC requires a minimum of 2 hours of supervision every month.

26. Invoices: Due dates are per invoice. You will be billed monthly for any balances due. We communicate with our clients to resolve past due accounts in all cases. If we cannot reach a client by phone following the return of undeliverable mail, or if a client's payment agreement cannot be made or paid as agreed, we are forced to use the services of a professional collection agency.
Once an account is placed with a collection agency, we cannot take the account back. Please let us know when or if your contact information changes so that we can always reach you, if needed, to discuss past due accounts.

27. Please contact your Clinical Supervisor about any treatment questions or concerns. The importance of continuity between home and Pediatric Therapy Studio, LLC cannot be over-stressed. Our aim is to develop an honest, open and supportive relationship with you, which complements life in your home rather than contradicts it.

We are very aware of our influence as a role model for your child and without your extensive knowledge of your child we would be unable to enhance your child's development. Pediatric Therapy Studio, LLC staff are always willing to discuss your child and their development. Please understand that therapist and supervisors do work with multiple families and may not be able to return calls immediately. If possible, email or text, and expect a response within 48 hours.

28. I have been given my own copy of Pediatric Therapy Studio Program Guidelines.

PRINTED NAME:_____
RELATIONSHIP:_____
SIGNATURE:_____
DATE:_____

Pediatric Therapy Studio

STATEMENT OF INDIVIDUAL PARTICIPANT RIGHTS

You have the right:

(a) Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age or disability;

(b) Be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences;

(c) Be treated with respect, dignity and privacy, except that staff may conduct reasonable searches to detect and prevent possession of contraband on the premises;

(d) Be free of sexual harassment;

(e) Be free of exploitation, including physical and financial exploitation;

(f) Have all clinical and personal information treated in accord with state and federal confidentiality regulations;

(g) Review your clinical record in the presence of the administrator or the designee and be given an opportunity to request amendments or correction;

(h) Lodge a complaint or grievance with the agency, U.S. Secretary of Health and Human Services if applicable, if you believe your rights have been violated; and

(i) File a complaint with the Virginia Office of Licensing if you feel the agency has violated a requirement regulating behavior health agency.

CHILD NAME: _____
PARENT PRINTED NAME:_____
RELATIONSHIP:_____
SIGNATURE:_____
DATE:_____

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CONSENT CONTRACT ACKNOWLEDGEMENT AND CONSENT FORM

DATE: _____

CHILD NAME: _____

1. Informed Consent: I agree to have my child receive services from Pediatric Therapy Studio, LLC utilizing ABA based interventions.

2. Release of Liability: I consent to the participation of my son/daughter in ABA therapy sessions, and agree on the behalf of the minor listed above to all of the terms and conditions of this agreement.

3. Acknowledgment of Receipt of Parent Handbook: This acknowledges that I have received, read and understand the parent handbook in its entirety.

4. Statement of Individual Participant Rights: This acknowledges that I have received, read and understood my child's and mine individual rights.

CHILD NAME: _____
PARENT PRINTED NAME:_____
RELATIONSHIP:_____
SIGNATURE:_____
DATE:_____

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CONSENT FOR APPLIED BEHAVIOR ANALYSIS SERVICES FORM

This document describes the nature of the agreement for professional services, the agreed upon limits of those services, and rights and protections afforded under the Behavior Analyst Certification's Board's Guidelines for Responsible Conduct of Behavior Analysts.

I will receive a copy of this document to retain for my records.

TREATMENT TEAM AND GOALS: I, _____ (parent/guardian) agree to have my child _____ _____, participate in applied behavior analysis (ABA) assessment and/or treatment services by Pediatric Therapy Studio, LLC. I understand that the specific activities, goals and desired outcomes of these ABA services will be fully discussed with me, and that I will have the opportunity to ask for clarification prior to signing this document. I also understand that I have the right to ask follow-up questions throughout the course of service delivery to ensure my full participation. My insurer and/or CSB also has rights regarding the services that are provided and all services and types of services may be subject to approval from my insurer or the CSB. I also understand that services will be designed primarily for my child's benefit. Any other individuals or agencies (i.e. siblings, family, daycare providers) who may be affected by the ABA are considered secondary clients.

ASSESSMENT: Part of the ABA services will focus on increasing my child's skills, and I understand that up to five sessions will consist of assessment activities designed to (a) evaluate his/her current skills (e.g. behavior and progress assessments) and (b) determine which instructional strategies and interventions are likely to prove most effective (i.e. preference assessments, assessment of prompting strategies). A part of the ABA services are designed to improve ongoing problem behaviors. I understand that the beginning of those services will include functional assessment and/or functional analysis activities (i.e. interviews, checklists, direct observations) that are designed to provide information critical to the development of effective treatment procedures. I may be asked to assist in gathering some of this information by recording problem behavior as it occurs. This process may take 1 to 2 weeks prior to implementing intervention.

TREATMENT: I understand the subsequent services will be focused on development of and implementation of instructional procedures and/or a behavior intervention plan. Prior to implementation, I will receive a printed copy of the results f any assessments and of any proposed instructional procedures or behavior intervention plans for my approval. The contents of those documents will be explained to me full and any questions I have will be answered to my satisfaction. Subsequent implementation will involve training in the basics of ABA that are important for the intervention, details about the specific components of the ABA intervention, and the direct practice in the components for the family, educators, and/or other service providers.

INITIAL PAGE:_____
CHILD NAME:_____

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CONSENT FOR APPLIED BERA VIOR ANALYSIS SERVICES FORM CON'T

EVIDENCE-BASED TREATMENT: Behavior analysts are ethically obligated to provide treatments that have been scientifically supported as most effective for autism spectrum disorders. I am aware that other interventions that I am pursuing may affect my child's response to ABA treatment. Thus it is important to make the behavior analyst aware of those interventions and to partner with the behavior analyst to evaluate any associated therapeutic or detrimental effects of those interventions. I understand that if I begin any alternative interventions that affect motivation or health I will inform my BCBA Supervisor.

PARTICIPATION: I understand full participation in these implementation and training activities is critical for a successful outcome. I understand that I am required to participate indirectly or directly a minimum average of 50% of the session time, with allowances made during initial sessions when rapport-building and assessment activities are taking place. Ongoing collection of data will allow evaluation of the effectiveness of the intervention and will assist in developing any revisions that need to be made to ensure a good outcome. When agreed upon goals are achieved, we will discuss the discontinuation of services as we will have achieved our therapeutic objectives. In addition, at regular progress reviews we may also discuss whether continuation of services would be beneficial and any barriers to continuation.

RIGHT OF REFUSAL: I reserve the right to withdraw at any time from these services and I understand that such a withdrawal will not affect child s right to services. In the event of withdrawal, the Clinical Director or BCBA Supervisor will be available to discuss provision of services. In addition, I reserve the right to refuse, at any time, the treatment that is being offered.

CHILD NAME: _____
PARENT PRINTED NAME:_____
RELATIONSHIP:_____
SIGNATURE:_____
DATE:_____

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Pediatric Therapy Studio

INFORMED CONSENT

CHILD NAME: _____
DOB: _____

I, _____ (parent/guardian) agree to have my child, _____ evaluated/treated through Pediatric Therapy Studio, LLC. I understand that these services are based on an Applied Behavior Analysis (ABA) model and will be provided by a professional trained in ABA. I understand that the state laws me require that confidentiality be broken under certain circumstances, specifically, if I am judged by the behavior analyst to be of danger to myself and/or others, gravely disabled, or if there is suspected child abuse.

I also understand that Pediatric Therapy Studio, LLC specializes in the evaluation and treatment of problem behaviors as well as skill acquisition, and if Pediatric Therapy Studio, LLC is unable to meet my particular needs, I will be referred to an appropriate agency or individual.

Services: Pediatric Therapy Studio, LLC implements the Applied Behavior Analysis for its services. A variety of techniques are integrated and utilized during treatment. You will be encouraged to practice various skills and introduced to sessions. A treatment plan with specific goals will be explored and updated according to treatment plan schedules. Recommendations for additional treatment and/or intensive treatment may be made, if needed.

When a client is a minor under the age of 14, parent/guardian/caregiver involvement is required during all visits with the client. Information will be limited to accommodate confidentiality with children of all ages. Family involvement is an important part of treatment. Children under the age of 18 will require a parent's signature (or legal guardian) to receive any form of treatment.

Concerns about services may be directed to Clinical Manager at 703-663-4808 or info@pediatrictherapystudio.com.

CHILD NAME: _____
PARENT PRINTED NAME:_____
RELATIONSHIP:_____
SIGNATURE:_____
DATE:_____

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Pediatric Therapy Studio

FUNCTIONAL BEHAVIOR ASSESSMENT CONSENT FORM

As a way to best serve your child we would like to conduct a Functional Behavior Assessment (FBA). A Functional Behavior Assessment is the process of collecting information to help identify student behaviors that interfere with learning and to determine why these behaviors occur. An FBA may include, but is not limited to:

- Interviews completed with teacher(s), parent(s)/guardian(s), and the student (if applicable) regarding the student's behavior.
- Information-gathering tools (e.g., cumulative file review, behavior rating scales, teacher rating scales, student self-assessment.)
- Observations of student behavior in the school setting
- Data collection on student behavior

The purpose of the FBA is to collect information to help develop a Behavior Intervention Plan (BIP) for your student to improve his/her performance and success in school. The BIP may include, but is not limited to:

- Interventions to prevent and reduce problematic behaviors
- Teaching new, appropriate replacement behaviors
- On-going data collection to evaluate the effectiveness of the plan
- Safety or crisis plan, if necessary

The FBA should be completed and shared with you within 15 business days after the assessment is concluded. If you have any questions regarding this process, please call the Clinical Manager at 703-663-4808.

Please check and sign below to indicate whether or not you consent to a Functional Behavior Assessment (FBA) on your child.

_____ I give consent to conduct a Functional Behavior Assessment on my student.

_____I do not give consent to conduct a Functional Behavior Assessment on my student. No response to requests to obtain parent consent.

CHILD NAME: _____
PARENT PRINTED NAME:_____
RELATIONSHIP:_____
SIGNATURE:_____
DATE:_____

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Pediatric Therapy Studio

CONFIDENTIALITY ACT ABUSE REORTING PROTOCOL

I understand all information related to my child's assessment and treatment must be handled with strict confidentiality. No information related to the client, either verbal or written, will be released to other agencies or individuals without the express written consent of the client's legal guardian. By law, the rules of confidentiality do not hold under the following conditions:

1. If abuse or neglect of a minor, disabled, or elderly person is reported or suspected, the professional involved is required to report it to the Department of Children and Families for investigation.

2. lf, during the course of services, the professional involved receives information that someone's life is in danger, that professional has a duty to warn the potential victim.

3. If our records, our subcontractor records or staff testimony are subpoenaed by court order, we are required to produce requested information or appear in court to answer questions regarding the client.

CHILD NAME: _____
PARENT PRINTED NAME:_____
RELATIONSHIP:_____
SIGNATURE:_____
DATE:_____

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Pediatric Therapy Studio

PERMISSION TO PHOTOGRAGH/VIDEOTAPE

_____I give permission and consent for Pediatric Therapy Studio, LLC to photograph my child and/or myself during the time my child is enrolled in services. I understand these photographs may be used in education training presentations.

_____I **do not** give permission and consent Pediatric Therapy Studio, LLC to photograph my child and/or myself during the time my child is enrolled in services.

_____I give permission for Pediatric Therapy Studio,LLC to use fill-face photographs of my child to promotional or marketing materials.

_____I **do not** give permission for Pediatric Therapy Studio,LLC to use fill-face photographs of my child to promotional or marketing materials.

_____I give permission for Pediatric Therapy Studio,LLC and/or audio tape my child and/or me during the time my child is enrolled in services. I understand these tapes will not be used outside the company and will be kept confidential. I understand that the tapes will be used to the purposes of developing more effective education and therapeutic plans for my child and also for the purpose of education and training for Pediatric Therapy Studio, LLC.

_____I **do not** give permission for Pediatric Therapy Studio,LLC and/or audio tape my child and/or me during the time my child is enrolled in services.

CHILD NAME: _____
PARENT PRINTED NAME:_____
RELATIONSHIP:_____
SIGNATURE:_____
DATE:_____

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Pediatric Therapy Studio

SERVICE COORDINATION

If your child is receiving any of the following, indicate the number of hours of service per day and the frequency of the service:

NAME OF PEDIATRICIAN: _____
NAME OF DEVELOPMENTAL PSYCHOLOGIST: _____
NAME OF NEUROLOGIST: _____
NAME OF DAYCARE/SCHOOL:_____

_____Special Education Services
_____Child Welfare-Targeted Case Management (CW-TCM)
_____Personal Care Assistant
_____Mental Health-Targeted Case Management (MH-TCM)
_____Recreational Therapy
_____Psychiatrist
_____Physical Therapy
_____Speech Therapy
_____Occupational Therapy
_____Other:_____
_____
_____

**If your family is currently not receiving Psychotherapy Services, is this something you are interested in? Please check below:

_____ YES _____ NO _____MAYBE LATER

CHILD NAME: _____
PARENT PRINTED NAME:_____
RELATIONSHIP:_____
SIGNATURE:_____
DATE:_____

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Pediatric Therapy Studio

FINANCIAL RESPONSIBILITY

- Clients who do not have any insurance coverage are expected to pay on a **monthly** basis. An invoice will be sent at the beginning of the month following services with an expectation payment is received by the end of the month. A sliding scale may be implemented to accommodate any financial difficulties on a case-by-case basis.

- Clients who are currently covered by insurance: The client is responsible to provide valid insurance information, and should provide their insurance card if it changes within five business days.

- It is important for you to make sure we are in-network and we are currently a provider with your insurance company.

- If we are currently a provider with your insurance company, the necessary forms will be completed and submitted, and secondary insurances will be billed when applicable.

- The client is responsible to pay any co-payment or any portion of the charges as specified by the plan at the time of the visit.

- Any medical services not covered by an individual's insurance plan are the client's responsibility and payment in full is due at the time of the visit. Specific coverage issues should be addressed by the insurance company's member services department (telephone number is on the back of your insurance card).

- The client is responsible to ensure that any required referrals for treatment are provided to the practice at the time of the visit. Visits may be rescheduled or the patient may be financially responsible due to the lack of the referral.

- We reserve the right to charge the completion of forms and letters. For example, insurance, or different programs, and the copying of records.

- Any outstanding balance either not paid in full or under a payment plan agreement can be transferred to an outside collection agency.

- A "no show"/ late cancellation fee may be charged to clients who do not provide at least 24 hour notice for canceling scheduled appointments or who fail to keep scheduled appointments without calling to notify the scheduling secretary or clinician.

CHILD NAME: _____
PARENT PRINTED NAME:_____
RELATIONSHIP:_____
SIGNATURE:_____
DATE:_____

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Health Insurance Portability and Accountability Act (HIPAA)

Notice of Privacy Practices

This notice describes how protected health information about a client may be used and disclosed and how the client can gain access to this information. Please review it carefully.

Pediatric Therapy Studio, LLC understands we collect private and/or potentially sensitive medical information about each client and/or the client's family. We call this information "protected health information." This notice explains the client's privacy rights and addresses how Pediatric Therapy Studio, LLC may use and disclose protected health information.

Pediatric Therapy Studio, LLC does not use or disclose protected health information unless permitted or required to do so by law.

Pediatric Therapy Studio, LLC must adhere to laws aimed at securing the privacy of the client's protected health information. These laws are known as the Health Insurance Portability and Accountability Act (HIPAA) privacy rules. When we do use or disclose protected health information, we will make every reasonable effort to limit its use or the level of disclosure to the minimum we deem necessary to accomplish the intended purpose. Please note that the privacy provisions articulated in this notice do not apply to health information that does not identify the client or anyone else.

For more information on Pediatric Therapy Studio< LLC privacy practices, or to receive another copy of this notice, please contact:

Pediatric Therapy Studio
8221 Old Courthouse Road
Suite 105
Vienna, VA 22182

or visit our website at www.pediatrictherapystudio.com

CCHILD NAME: _____
PARENT PRINTED NAME:_____
RELATIONSHIP:_____
SIGNATURE:_____
DATE:_____

Health Insurance Portability and Accountability Act (HIPAA) CON'T

Protected Health Information

Protected health information is information about the client relating to a past, present, or future mental health condition, or treatment or payment for the treatment that can be used to identify the client. This includes any information, whether oral or recorded in any form, that is created or received by Pediatric Therapy Studio, LLC. This also includes electronic information and information in any other form or medium that could identify the client.

The patient may revoke this Consent in writing at any time and all future disclosures will then cease. The Practice may condition receipt of treatment upon the execution of this Consent.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.

CHILD NAME: _____
PARENT PRINTED NAME:_____
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Pediatric Therapy Studio

Acknowledgment That You Have Received Our HIPAA Privacy Notice

Pediatric Therapy Studio< LLC is required by law to keep your health information safe.

This information may include:

- notes from your doctor, teacher, or other health care provider
- your medical history • your test results
- treatment notes
- insurance information

We are required by law to give you a copy of our privacy notice. This can _jqm be downloaded from our website ,

This notice tells you how your health information may be used and shared. It also tells you how you can look at and comment on your information.

By signing this page, you are saying that you have been given a copy of our privacy notice.

2106-G Gallows Road Vienna VA 22182
T: 703-957-9256 F: 703-665-1241 E:palmajid@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.

   _____

   Parent/Caregiver/Guardian Printed Name:

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Email: info@pediatrictherapystudio.com

Pediatric Therapy Studio

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.

_____

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

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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Acknowledgment of Receipt of Parent Handbook

This acknowledges that I have received, read and understand the parent handbook in its entirety.

CHILD NAME: _____
PARENT PRINTED NAME:_____
RELATIONSHIP:_____
SIGNATURE:_____
DATE:_____

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