INTEGRATED
Pediatric Therapy

website http://ipedtherapy.com/.

Email:ipedtherapy@gmail.com

Ph: 480-729-5700

Client Policies and Procedures Agreement

Thank you for your interest in our services. As a private occupational therapy clinic, our goal is to provide high-quality services that are beneficial to the family we serve and to collaborate with other professionals as necessary. In order to assure that you and your child receive the best possible treatment, please review and sign the following agreement.

Length of Treatment

Individual therapy sessions are 60 minutes; typically, 50 minutes of direct hands on contact and 10 minutes at the end of the session used to share information with parents, or for time to transition after the session, and do documentation. Written documentation (a progress report) is provided at the end of every 6 months.

Appointment Scheduling and Cancellation Policy

We try to accommodate all scheduling requests, and ask that you be on time for your appointment. If, on occasion you know you will be late, please contact us at 480 729 5700 . with an approximate arrival time. If you arrive more than 25 minutes late, there may not be sufficient time for a productive session and a cancellation fee will apply.

Integrated Pediatric Therapy maintains a 24-hour cancellation policy. You will be billed for any missed appointment unless you provide us with at least 24-hours notice of cancellation. Cancellations are allowed for illness and family emergencies. Otherwise we ask that you honor the commitment we make to you to provide services; continuity of service is very important. We also will try to re schedule your appointment within the same calendar week.

In the case of illness, please notify us directly by 8 am at **[*480-729-5700*]**. If the appointment begins earlier than 9 am, please call at least one hour before your scheduled appointment time. Otherwise, you will be billed and are responsible for the missed appointment.

We reserve the right to release your appointment time to another family should we find that you have excessive cancellations. Please let us know about summer and other vacations as soon as you know about them, ideally a minimum of 30 days in advance.

Payment for Services Rendered

Services are rendered in the good faith that they will be paid for. Our fees for service is as follows:

Initial Evaluation with Standardized Testing /Written Report___

Initial Evaluations – No Formal Testing/Written Report __

1:1 Treatment Session ___

You will be billed at the end of each week and payment is expected upon receipt of bill.

Payment options include ____________________________________

Bills not paid within 30 days of the billing date will incur a $25 late fee, and returned check will incur a $25 fee.

Bills not paid within 60 days of the billing date will result in termination of treatment until the account is paid in full. This may lead to loss of preferred treatment time and/or placement on the Integrated Therapy waiting list if alternative treatment times are not available. Accounts that are more than 90 days delinquent will be submitted for collection.

We are an out of network provider and will provide you with a bill for services rendered which you can submit to your insurance company, Health Savings Account or Flexible Saving Account for potential partial or full reimbursement. We make no representation that you will be reimbursed in part or in full.

On a case by case basis, we can offer a prompt or pre pay discount, and consideration for financial hardships. We may also be able to help you get coverage through Network Gap Exceptions.

Below, parents must provide comprehensive contact information including parent's names, home and business addresses, phone numbers (home, work & mobile), e-mail addresses and an emergency contact name & phone number.

I have read the above Policies and Procedures, understand them in full, and agree to their terms.

_____________________ _____________________

Signature Date

Name of Child Receiving Treatment: ______________________________

Parents or Guardians Names: _____________________________________

Home Address: ____

Home Phone: ________________

Business Address: ____

Business Phone: _______________

Cell Phone: ______________

E-mail Address: ________________________

Emergency Contact (Name & Phone): ________________________________

We are committed to collaborating with other healthcare professionals involved in the care of your child. Please provide the name and contact information for those we can share progress reports such as your pediatrician, neurologist, pediatric ophthalmologist etc.

Name ____
Address: _____________________________________ email ______________

Name ____
Address: _____________________________________ email ______________

Name ____
Address: _____________________________________ email ______________