Client: _____

OCCUPATIONAL THERAPY CONNECTIONS
6801 LAKE PLAZA DRIVE, SUITE A101a
INDIANAPOLIS, IN 46220
317-581-1185

POLICIES OF OCCUPATIONAL THERAPY CONNECTIONS LLC

We welcome you to our clinic and are pleased to begin therapy services with you and your family. Please find the clinic policies for your review and signature. Please let us know of any questions that you might have.

Appointment Policy

Attendance: You and your therapist will agree on a regularly scheduled therapy appointment time. Regular attendance for therapy is needed in order to make progress and meet your goals. ***Please schedule your other activities and appointments around this therapy appointment so that you can attend your therapy sessions regularly as scheduled.***

Cancellations: Appointments must be cancelled at least 24 hours before the scheduled appointment. Except in cases of emergency or illness, appointments cancelled later than 24 hours before the appointment will be charged a fee of $40.00. If there are frequent cancellations or no shows this may result in a need to find a different therapy appointment time and loss of your current appointment time.

Cancellation Due to Illness: Please do not attend treatment if you, your child, or anyone else accompanying you is ill. This helps protect the health of our other clients and staff. You will not be charged for a missed appointment if you cancel due to illness is your child or you:

- *is ill or has an infectious illness*
- *has not gone to school or work*
- *has had a fever within 24 hours (you or your child may return to the clinic if free from a fever for 24 hours and not using a fever reducing medication such as Tylenol)*
- *has a sore throat or laryngitis*
- *has a cough with phlegm*
- *has body or muscle aches*
- *has vomited in the past 24 hours*
- *has pink eye*
- *has lice*

Bad Weather Cancellation Policy: Please call this clinic if driving conditions are poor. We will be happy to re-schedule your treatment appointment.

Appointment Reminders

We will attempt to remind you of your appointments; however, it is your responsibility to remember scheduled appointments.

Office Closings

You will be notified of any dates the office will be closed. In case of emergency or illness, you will be notified as far in advance as possible. Your treatment appointment will be re-scheduled as promptly as possible.

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Financial Policy

Fees and Payments: Fees for therapy services will be discussed with you before beginning services and fees shall be paid at the time of each visit or by payment arrangement. Occupational Therapy Connections LLC accepts payment by cash, check, and credit card (including HSA cards).

Brief conferences between sessions, as well as brief telephone conference or email communication are considered part of the regular intervention program, and no additional charges will be made. Conference (via telephone or in person) with family, school staff, physicians, tutors, counselors, or others that exceed 15 minutes in length will be charged at the regular billing rate.

Additional Fees

- ***Supplies***: Any supply purchased by you.
- ***Returned Check***: A fee of $35.00 will be charged for any returned check.
- ***Reports/Letters:*** Fees for reports other than those typically provided by this clinic will be charged at the regular billing rate.
- ***Outside Meetings:*** Outside meetings and travel will be charged at the regular billing rate at a minimum of one hour (not covered by insurance).
- **Unpaid Account**: Unless other arrangements are made, any balance on the account that remains unpaid for more than 60 days may be assessed a rebilling fee of $25.00. If a balance remains unpaid for more than 90 days, the account may incur an additional $50.00 rebilling fee. Once a balance goes unpaid past 100 days, the account may be turned over to a Third Party Billing Service.

Insurance

- Occupational Therapy Connections is typically considered out of network. You may wish to check with insurance to determine if you have out of network benefits for outpatient occupational therapy.
- Sometimes your insurance company may consider in network benefits for our clinic if there's not a pediatric occupational therapy specialist within a certain proximity.
- We will provide you with a superbill payment receipt that may be submitted to insurance if you wish. Please contact the insurance company to determine if there is a claim form that must also be completed and submitted with each claim. Our clinic will be glad to assist with the claim form completion. You will be responsible for submitting the claims to your insurance company.

Consent to Use Email Communications

If you approve of email communication with Occupational Therapy Connections LLC you may choose if email is encrypted or not encrypted. There can be risks to sending Protected Health Information (PHI) through email even with encryption. If you agree to email communication:

- You accept that Occupational Therapy Connections shall not be held responsible for any exposure of email communications at your home or place of employment, depending on the location of your email address
- You understand that email communications can fail in their transmission and you agree to contact Occupational Therapy Connections if you do not receive a response to your email to us within two business days.
- You understand all appointment reminders are sent via unencrypted email.
- You will choose how other emails are sent to you encrypted or unencrypted.
- You understand that if you agree to email communication now you may terminate this agreement at any time.

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General Policies:

- **Scented Products**: Due to patient sensitivities, please do not wear scented body care products on the day of your appointment (i.e., scented lotions, colognes, fragranced hair care products, etc.).

- **Remain in Clinic**: Please remain in this clinic the entire treatment session.

- **Cell Phone Use**: Please turn off the ringer on the cell phone. Please do not use your cell phone while in the waiting room unless there is an urgent situation. If you must use your phone, we ask that you use a soft voice while speaking or step outside in order to not disturb others.

- **Waiting Room:**
  - You are welcome to use the literature and any toys that are available in the waiting room. Please return items to their appropriate places and assist your child in putting away toys.
  - If siblings are in the waiting room, we encourage you to bring age-appropriate activities for them to enjoy while waiting.
  - We ask that children use "inside voices" and play quietly. Please monitor your children's play in the waiting room and not allow rough or loud play, standing or jumping on chairs, or hanging on the office window ledge.
  - Children must be in a treatment room with their family or the waiting room – they may not be in the hallways.

- **Food**: We ask that you please not bring meals for the client or family into the clinic (including treatment room and waiting room) unless approved by the therapist.

- **Restroom**: When you child is not in a therapy session, you are responsible for monitoring his/her use of the bathroom and bathroom use of your other children.

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POLICIES OF OCCUPATIONAL THERAPY CONNECTIONS LLC

Signature Page (please return this page)

- I have read and accept the policies of Occupational Therapy Connections LLC

  _____ (initials)

- I understand that I must provide a 24 hour notice of cancellation unless it is an emergency or illness situation. If I do not provide a 24 hour notice of cancellation in nonemergency situations, I will be charged $40.00.

  _____ (initials)

- I have been offered a copy of the Notice of Privacy Practices
  (available on the website www.otconnections.com New Referral Password: new)

  _____ (initials)

- I consent to use of email communications.

  _____Yes _____No _____ (initials)

  If yes, preferred email address: _____

- I understand that my financial agreement is with Occupational Therapy Connections LLC. I am responsible for submitting claims to my insurance.

  _____ (initials)

- I agree to the financial policies of Occupational Therapy Connect ions LLC. I understand I am responsible for payment of all fees for services provided. If my fees are unpaid past 100 days, I agree that I will pay all returned check fees, collection fees, attorney, fees, and court costs incurred for the collection of fees.

  _____ (initials)

_____ _____

Patient/Legal Guardian Signature Date Signed

_____

Relationship to Patient