



## TW2 Policies & Financial Forms

Please enter the Access Code provided to fill out the form.

### Child's Name \*

First Name      Last Name

### Child's Date of Birth \*

Month   Day   Year

### Parent/Caregiver completing this form: \*

First Name      Last Name

### Relationship to Child \*

### Name of Primary Contact \*

First Name      Last Name

### Email \*

example@example.com

**Cell Phone Number \***

**Address \***

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

**Name of Secondary Contact**

First Name

Last Name

**Relationship to Child of Secondary Contact**

**Cell Phone Number of Secondary Contact (Additional Parent/Caregiver)**

**Address of Secondary Contact (if different)**

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

**Welcome to Therapy West 2. We appreciate the opportunity to work with you and your child. The following policies have been designed to help guide you through the procedures at Therapy West 2.**

## **THERAPY AGREEMENT & CONSENT**

Your signature below forms a binding agreement between Therapy West 2 and the Responsible Party for minor patients. Responsible Party is the individual who is financially responsible for payment of services. I understand that I am financially responsible for all services provided.

Services will be billed weekly, at the end of each week. A valid credit card must be kept on file, and cards will be charged automatically for services rendered and any outstanding balance. If I am using Step Up for Students funding, I understand that funds must be reserved prior to the session in order to avoid charges to my card.

All invoices related to comprehensive and consultative evaluations must be resolved and payments made before the full evaluation report is released.

Please note that we do not bill insurance directly. However, TW2 is happy to provide a monthly superbill upon request that you may submit to your insurance provider for potential reimbursement.

### **Name of Responsible Party \***

First Name

Last Name

## **FEE SCHEDULE**

### **Comprehensive Evaluation** \$525

-Full evaluation with standardized testing of multiple developmental areas. A written report will be provided to parents as well a 15 minute meeting with the therapist to discuss the results. If treatment is warranted, a plan of care and goals will be created upon initiation of treatment. Approximate length of time is 1.5 hours.

### **Combined OT and Speech Comprehensive Evaluation** \$900

-Only for children up to 2nd grade. Full evaluation with standardized testing across occupational therapy and speech and language developmental areas. A combined OT/SLP written report will be provided to parents as well a 15 minute meeting with the therapists to discuss the results. If treatment is warranted, a plan of care and goals will be created upon initiation of treatment. Approximate length of time is 3 hours.

### **Consultative Evaluation** \$375

-Consultative Evaluation with standardized testing and clinical observations will be conducted and written report will be provided to parents as well a 15 minute meeting with the therapist to discuss the results. If treatment is warranted, a plan of care and goals will be created upon initiation of treatment. Consultative evaluations are only available for concerns related to articulation, fine motor/handwriting, social skills and specific executive function. Approximate length of time is 1 hour.

### **Re-Evaluation** \$275

-Required re-evaluation every 6-9 months or at time of discharge to measure progress.

### **OT/ST Individual Treatment** \$140/hour

-Sessions are 50 minutes in length including time to discussion with parent. If appropriate, sessions can be pro-rated for shorter duration.

### **Early Detection Dyslexia Testing** N/A

### **Language & Dygraphia Evaluation as part of a Psycho-Educational Evaluation**

\$250/hour for testing

\$150/hour for writeup

-Full language and writing evaluation with standardized testing to evaluate dyslexia and dysgraphia as part of a Psycho-Educational Evaluation. A written report which is completed in conjunction with Psychologist will be provided to parents. If treatment is warranted, a plan of care and goals will be created upon initiation of treatment. Approximate length of time is 2.5-3.5 hours.

\*\*Park Maitland charges Therapy West 2 a \$10 per hour facility-use fee for therapy space. Starting on July 1,

2025, sessions conducted on the campus of either Park Maitland main campus or Park Maitland Preschool will assess the following additional fee:

For a 30-minute session, \$5.00 per session

For a 45-minute session, \$7.50 per session

For a 60-minute session, \$10.00 per session

You will be billed for all services at the end of each day. Your insurance will not be billed. It is your responsibility to file a claim with your insurance company. Payment must be made within 10 days in order to continue treatment.

If a payment is made on an account by check and the check is returned as Non-Sufficient (NSF), Account Closed (AC), Refer to Maker (RTM) or a Stopped Payment, the Responsible Party will be responsible for the original check amount in addition to a \$35.00 Service Charge. Once notice is received of the returned check, Therapy West 2 will notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance – in addition to the \$35.00 Check Service Charge.

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that Therapy West 2 has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patients Responsible Party understands that they are responsible for all cost of collection including, but not limited to: interest due at 18% APR, all court costs and Attorney fees and a collections fee will be added to the outstanding balance.

**I consent to the following services for my child: (please mark all that apply) \***

OT Evaluation

OT Treatment (Requires having a recent OT evaluation)

SLP Evaluation

SLP Treatment (Requires having a recent ST evaluation)

Groups

Early Dyslexia & Dysgraphia Testing

Language & Dysgraphia Evaluation as part of a Psycho-Educational Evaluation

Other

**Type of evaluation/treatment you are scheduling: (N/A if already have evaluation and are seeking treatment). If unsure, this can be discussed prior to evaluation. \***

OT Comprehensive Evaluation

OT Consultative Evaluation (Note: if sensory processing is a concern, this would be a comprehensive evaluation)

SLP Comprehensive Evaluation

SLP Consultative Evaluation (for concerns like articulation)

Language & Dysgraphia Evaluation as part of a Psycho-Educational Evaluation

Speech Therapy Treatment Only (Please Provide previous ST evaluation)

Occupational Therapy Treatment Only (Please Provide previous OT evaluation)

Not sure, would like to discuss prior to evaluation

Other

**By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services. Your signature verifies that you have read the above disclosure statement, understand your responsibilities and agree to these terms.**

## Today's Date: \*

Month Day Year

### TERAPY ATTENDANCE POLICY

Attending 80% of therapy appointment is mandatory. Attendance rates below 80% or not calling to cancel a scheduled appointment may result in removal from the schedule.

If your child is ill, please call to cancel your appointment. If your child has a prolonged illness (2 consecutive cancellations due to illness) or contagious illness, you must bring a medical clearance from your doctor in order to resume therapy. To cancel an appointment, please notify your therapist or leave a message at (407) 900-3026. When leaving a message, please include the time of appointment being canceled, the therapist(s) name and the available days and times the session can be made up.

Make up sessions are not guaranteed and are subject to time and therapist availability.

A prorated fee of half the session rate will be assessed for appointments canceled with less than 24 hours' notice (this will be assessed on an individual basis), as well as for no-shows to scheduled sessions, whether in the clinic or at school.

Please remember that it is the parent or guardian's responsibility to notify your therapist if your child will not be attending a session for any reason—including illness, vacation, or school-related activities such as field trips. If you're ever unsure, don't hesitate to reach out to your therapist directly.

If you have questions or require more time to talk with your therapist, please make an appointment to talk later by telephone. Consultations (in person or on the phone) that exceed 10 minutes will be charged in 15 minutes increments at the rate of a private therapy session.

It is mandatory that your child be picked up on time after their session. A \$20.00 per 15 minutes or fraction thereof will be charged to the parent and must be paid at the time of pick up.

If you are leaving the premises during your child's therapy time, please make sure that your therapist has a means of contacting you.

Therapy sessions are often video taped by your treating therapist (especially if your child is under 1 year of age) for record keeping documenting progress and in order to assist your therapist with future treatment planning. Videos are also used for other educational purposes. Photographs are taken regularly for our TW newsletters or to display on our walls at Therapy West 2. A photo/videotape release form is included in your new client packet for this purpose. It is optional to sign this release and you are free to stipulate the terms for videotaping and photographing your child. You may be asked to provide Therapy West 2 a copy of any home videos that you have of your child between 8-12 months of age (which will be kept confidential). This is helpful in better understanding the early development of your child.

### FACILITIES POLICY

Street shoes are not allowed on the therapy mats. Food, drinks, and cell phones are not allowed in treatment areas. Siblings are NOT allowed in the treatment areas. Parents or other adults are not allowed to supervise any child on any Therapy West equipment. Parents are required to sit in the waiting room or in a "Parent Observation Chair" if observing a session.

If there are other persons or professionals that would like to observe your child's session, please notify your therapist at least 1 week before. Therapy West 2 welcomes these visitors, but requires that a designated supervisor be present during the observation and that the visit be limited to 20 minutes.

## Today's Date \*

Month Day Year

### VIDEO, PHOTOGRAPHY & SOCIAL MEDIA CONSENT

At Therapy West 2., therapists videotape or photograph children who receive therapy services to help monitor and document a child's areas of concern, as well as measure their progress. Videotapes and photos are used and reviewed by Therapy West 2 staff and occasionally may be used in research projects focusing on

outcome measures.

Therapists are frequently asked to participate in research and teach at professional courses, seminars or workshops nationally and internationally, as well as to write articles or chapters in technical books. We often include videotapes, slides or photos during our presentations. If photos or videos are used for any of the above mentioned purposes, they will not have identifiable information. Parents are always welcome to view their child's videotape at Therapy West 2.

**I give consent for my child to be videotaped and/or photographed. I understand that my child's name and any identifying information will not be used in association with these images. \***

Yes

No

Therapy West 2 maintains a brochure, website, Facebook page and Instagram page. Please mark your consent for staff and therapists at Therapy West 2 to take photographs and videos of my child for the purpose of posting on these sites. With this consent, I hereby release and discharge Therapy West 2 from any and all claims arising out of use of the photos and videos. This consent can be changed and revoked by parent at any time.

**I provide consent for Therapy West 2 to use photographs of my child on Therapy West 2's brochures: \***

Yes

No

**I provide consent for Therapy West 2 to use photographs and videos of my child on Therapy West 2's website: \***

Yes

No

**I provide consent for Therapy West 2 to use photographs and videos of my child on Therapy West 2's Facebook and Instagram pages. I understand that these posts may be accompanied with my child's first name. : \***

Yes

No

**Today's Date \***

Month   Day   Year

## **HIPAA PRIVACY NOTICE**

### **NOTICE OF PATIENT INFORMATION PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

#### **THERAPY WEST 2's LEGAL DUTY**

Therapy West 2 is required by law to protect the privacy of your personal health information (PHI), and to provide this notice about the information practices we follow.

#### **USES AND DISCLOSURES OF HEALTH INFORMATION**

Therapy West 2 uses your PHI primarily for treatment; obtaining payment for treatment; conducting internal

administrative activities and evaluating the quality of care that we provide. For example, Therapy West, Inc. may use your PHI to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Therapy West 2 may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We also provide information when required by law.

In any other situation, Therapy West 2's policy is to obtain your written authorization before disclosing your PHI. If you provide us with a written authorization to release your information for any reason, you may alter revoke that authorization to stop future disclosures at any time.

Therapy West 2 may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

#### PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your PHI at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances when we have disclosed your PHI for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your PHI for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Therapy West, Inc. will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

#### CONCERNS AND COMPLAINTS

If you are concerned that Therapy West 2 may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your PHI, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Therapy West, Inc.'s health information practices or if you have a complaint, please contact one of the owners.

### **Today's Date: \***

Month   Day   Year