**Office Policy 2020**

I would like to provide you with the following information regarding my scheduling, cancellation, and payment policies, which will remain in effect for the 2016-2017 school year. Please take a few minutes to review this letter. Please initial where indicated, sign and return a copy of this contract prior to the start of therapy.

**Scheduling and Cancellation Policy:**

1. Please understand that your child’s therapy time is reserved for him or her only. You will be billed the full amount for any session cancelled less than **24 hours in advance**. Excessive cancellations (more than 3 a month) may result in a trial period of 30-60 days to determine if the child can continue to keep their time slot.
2. If you need to cancel, it is important to contact me by phone, not email.
3. Your child must be picked up on time regardless of whether your child is late for his or her appointment. Please arrive at least 5 minutes before the end of the session. Arriving early will allow us to spend a few minutes to discuss your child’s progress.
4. If your child is sick/contagious, please do not bring your child in for therapy. **If you do not send them to school, please do not send them to the office**. If your child arrives sick, they will be sent home and you will be charged for the full session. The following must be observed:

\*Your child must be free from a productive cough/cold, pink eye, lice, fever, vomiting, and/or diarrhea for at least **24 hours** before they can return to therapy.

**I have read the Scheduling and Cancellation Policy. I understand and agree to follow the terms of the above Policy. \_\_\_\_\_\_\_ (initials)**

**Payment Policy:**

1. Please discuss a payment schedule at the start of therapy. You may pay either weekly or monthly. If you opt for a monthly bill, payment is expected within two weeks of receipt of the bill.  If payment is not made in a timely manner, this clinician reserves the right to temporarily suspend services until payment is cleared.  **If the payment is not received within the first 2 weeks of the following month and you have not notified us as to when the payment will be received, you will incur a 1% fee, which will be applied weekly until the payment is received.**
2. Bounced checks will incur a $25 fee. If you bounce a check, you will be required to pay in cash or money order for the duration of your child’s therapy.

**I have read the Payment Policy.** **I understand and agree to follow the terms of the above Policy. \_\_\_\_\_\_ (initials)**

**Insurance Policy:**

1. Advance Kids in Motion OT, PLLC does not accept insurance, however, we will try to help you gain reimbursement when appropriate but we offer no guarantees your insurance will cover the therapy. **If you are seeking reimbursement, please note that you must submit to your insurance company within the first 30 days of the therapy start date. Failure to get reimbursed is your obligation and Stephanie Bronstein, Advance Kids In Motion OT, PLLC assumes no responsibility for the failure of the insurance company to reimburse you.**
2. If you require an invoice for your insurance company, please request this at the start of therapy. Please remember that most insurance companies do not cover therapy costs for developmental delays and educational goals. Please call your insurance company before the start of therapy to verify your coverage.
3. The parents or guardians are responsible for all payments. It is not acceptable to wait to pay Stephanie Bronstein and Advance Kids in Motion OT, PLLC until after you have been reimbursed by the insurance and/or received an insurance determination. Payment is due as discussed above in the Payment Policy section of this document. Further, this practice does not accept direct pay from insurance companies. **If we receive a check from your insurance company, it will be returned to them. We will not sign over nor cash and issue you a check.** Please make sure to mark your forms appropriately so that **you** receive the reimbursement check.

**I have read the Insurance Policy.** **I understand and agree to follow the terms of the above Policy. \_\_\_\_\_ (initials)**

**Additional Charges:**

1. Please be advised that time spent handling requests outside of your child’s scheduled therapy sessions will be billed at the hourly rate. A minimum of two weeks notice must be provided to receive a report by the requested due date. Among others, the following will be subject to this policy:

\*Parent conferences

\*School conferences

\*Phone conferences

\*School visits

\*Extended reports

**I have read the Additional Charges Policy.** **I understand and agree to follow the terms of the above Policy. \_\_\_\_\_\_ (initials)**

**A few reminders:**

1. If you step out while your child is in session, make sure you are accessible by phone, have provided our office with the phone number to reach you and are within a two-block radius.
2. We are not responsible for toileting needs.
3. Please be respectful of the common space and clean up after your child.
4. Please keep cell phone conversations to a minimum.
5. This is a peanut and tree nut free office. If your child has any allergies, please disclose them at the start of therapy.
6. Please whenever possible bring a fold up stroller. The office has room for only 1 stroller at a time.
7. Violation of any of these rules or policies can result in the cancellation of the therapy or termination of the relationship solely at the discretion of Stephanie Bronstein and Advance Kids in Motion OT, PLLC.

**I have read the above reminders. I understand and agree to follow the above terms. \_\_\_\_\_\_ (initials)**

Thank you for taking the time to review these office policies. Your understanding and cooperation are greatly appreciated!

Sincerely,

Stephanie Bronstein, OTR/L

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist’s Name (Print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**I have reviewed and understand the policies as indicated herein. I further agree that I, the family caregiver(s) and my child shall comply with these policies.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian (Print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date