

Policies and Procedures

Please take a moment to review our policies and procedures. Once you have finished reviewing all the items, sign and date the last page. Please keep a copy for your files. We highly recommend reviewing these policies and procedures.

Scheduling

1. I understand Springboard Pediatric Therapy is a private clinic and that I am solely responsible for payment at the time when services are rendered.
2. I understand that the treatments are 50 minute hours. The treatment will be comprised of 50 minutes of hands on treatment and the remaining 10 minutes are allotted for consultation (5 min) and daily notes (5 min). You may choose not to have consultation time, note time is mandatory.
3. I understand that Springboard Pediatric Therapy and/or the treating therapist's have reserved a time slot(s) for my child. In order to maintain this reserved slot, my child must attend a minimum of **80%** of the scheduled sessions each month; otherwise I agree to forfeit my child's time slot and go into cancellation/as needed slots.
4. I understand and agree that notification of vacations or family obligations is requested at least two week prior (three weeks if possible) to the anticipated absence in order to facilitate re-scheduling.
5. I understand that **if my I do not show for a scheduled appointment or cancel a session at least 24 hours in advance, we will be charged \$95.00 and without codes for insurance.** Exceptions may be made for serious illness, hospitalization, emergencies, and other critical situations within reason as determined by the treating therapist.
6. I understand that if I arrive late for my appointment, I will be billed for the entire session. Make-up time is at the therapist's discretion and availability.
7. I understand that the therapist may be late to begin a session and that I will only be billed for the time spent in session. Springboard Pediatric Therapy will do it's best to be sure you are given the amount of time allotted. Make up time will be at the therapist's discretion and availability.
8. Snow Day Policy: I understand the clinic is open unless I am notified by the treating therapist of any delays or cancellations. I understand that I can cancel my session on a snow day without a charge secondary to poor weather and driving conditions. Make-up sessions will be made available whenever possible.
9. I understand that I am limited to one 30, 45, or 60 minute time slot as agreed when scheduling and that I will be charged the consultation fee in 15-minute increments for any time used beyond the regular treatment time slot. I also

understand that if I wish to have additional consultation time, I must schedule that time with my treating therapist ahead of time.

Office Policies

1. I understand that I am responsible for waiting with my child in the waiting area until the session begins. I also understand I am responsible for monitoring my child, my child's siblings or any other children who accompany me to Springboard Pediatric Therapy. ***I understand that no food and no beverages in open containers are allowed in the waiting room and absolutely NO MILK or NUT PRODUCTS ARE PERMITTED AT ALL.***
2. Due to the inherent danger of unsupervised play in our facility, **no children are ever allowed into the therapy area of the facility without a therapist present.** Any area beyond the waiting room is considered our therapy facility. Siblings and friends not enrolled in therapy are not allowed into the therapy facility beyond the waiting room unless given permission by the treating therapist with the appropriate liability forms filled out.
3. All families are asked to use the main bathroom in the hallway. The bathroom in the office is for therapists and clients in session only.
4. Springboard Pediatric Therapy is committed to family involvement in therapy. We are also committed to privacy and safety. In order to succeed in this, We have built in 5-15 minutes of training time into every session and more time can be allotted if needed. Training will take place in a private room when possible, but usually will be in the large gyms.
5. I understand that it is my responsibility to strictly supervise and escort all children in the parking lot, stair, and elevator area.
6. I understand Springboard Pediatric Therapy is in a business facility and that loud noises in the common areas are not tolerated. **Please modulate your children's behavior accordingly, particularly when using the restrooms.** Please clean up after your children using the supplied cleaning cloths when they have accidents in the bathroom.
7. Springboard Pediatric Therapy prefers to have families wait in the waiting room for the duration of the session for safety reasons. I understand that if I choose to leave, I am responsible for notifying the treating therapist of my plans and contact information so that I may be reached for questions about my child. I understand that if I leave, I am responsible for returning after 45 minutes in order to discuss my child's treatment with the therapist. I understand that if I return late, I will be billed accordingly.

Acknowledgement of Risk

1. I understand that there is some risk inherent in the use of therapy equipment at our clinic. I understand that the facility has trained all therapists in the proper use of this equipment and I agree to indemnify and hold Springboard Pediatric Therapy harmless from any and all losses and claims for any injuries and other damages occurring to myself or my child or our belongings from the use of therapeutic equipment.
2. I understand that I am responsible for waiting with my child (children) in the waiting area until therapy begins and for monitoring my child's or any children I bring with me, play in the waiting room. I agree to indemnify and hold Springboard Pediatric Therapy harmless from any and all losses and claims for any injuries and other damages occurring to myself or my child or our belongings from the use of furniture, toys, or equipment in the waiting room.

Financial Policies

1. I have initiated services and understand that I am responsible for payment at each session.
2. Acceptable forms of payment include cash, checks, and credit cards(Visa or MasterCard only). All checks are to be made out to Springboard Pediatric Therapy LLC.
3. Returned checks are subject to a \$30 fee.
4. Payment from insurance companies is not accepted, a claim receipt will be provided.
5. **I agree to have a current credit card on file.** All families are required to have a current credit card on file. If your family is uncomfortable with this policy you may choose to write us a \$280.00 check that will be cashed and used as a security deposit. This money will be applied as a credit in your account and applied to your last sessions with us. The cc or credited cash will only be used in the event that your family forgets to bring a check or cash for payment, cancel with less than 24 hours, or if your family chooses to use a credit card for payment. Springboard Pediatric Therapy will not use this card if a payment has already been made for the scheduled session.

Credit card type: _____

Credit card #: _____ CVC Code _____

Expiration Date: _____ Zip Code _____

Name on Card: _____

Signature: _____

6. I understand that payment is due at the time services are rendered. I understand that balances past due over 30 days are subject to a 10% monthly late charge. Balances over 60 days will result in discontinuation of therapy services and the balance will be sent to a 3rd party collection agency or filed in small claims court.
7. I understand that Springboard Pediatric Therapy is not obligated to complete insurance forms, follow specific procedures, or send claims directly to insurance companies.
8. I understand that outside of my initial evaluation procedure and conference, I am not entitled to any further documentation. If further documentation is required, I will be billed accordingly. All requests for documentation must be in writing for our files. A request for documentation sheet can be obtained from your therapist.
9. I understand that phone and email communications with me or my immediate family over 10-minutes will be billed in 15- minute increments under our consultation services fee.
10. I understand that any in-person, phone, or email conferences with schools, other professionals, other care givers, attorneys, insurance companies, etc will be billed at the consultation rate in 15 minute increments. No 10- minute grace periods allowed for interactions outside of the child's parents/guardians.
11. I understand that travel time is an additional expense for out of clinic meetings.
12. I understand that I need to fill out a release and consent form before Springboard Pediatric Therapy can discuss my child with any other individual.
13. I understand that if I request re-prints of my invoices I will be charged at 25 cents per copy.
14. I understand that any faxing I request is charged at \$1.00 per page. This includes faxing insurance.
15. I understand that if Springboard Pediatric Therapy takes me to Small Claims Court I am responsible for all court costs.

I have read and understand all the policies and procedures of Springboard Pediatric Therapy LLC. I agree to abide by all of the policies and procedures.

Signature

Printed Name

Date

Springboard Pediatric Therapy's rates for all clients are as follows:

Occupational Therapy 1 hour session \$140.00

Occupational Therapy 45 min session \$105.00

Unexcused cancellation \$95.00
(No show/ Less than 24-hour notice)

** If your child becomes sick, please be sure to call/email your treating therapist as early as possible. We often have children waiting for cancellation appointments. DO NOT leave a message on the main phone or in the main email. Thank you.

Rose Ann, our Billing Manager, is in on Wednesdays. If you have questions, send her an email at billing@springboardtherapy.com and she will call you when she's in on Wednesday.

We accept Visa/MasterCard and flexible spending account cards. As is our policy, all families are required to maintain an active credit card on file or provide a check for \$280.00 that we will deposit and we may use if necessary.

If your check is not used it will be applied to your final sessions. Thank you!

Patricia OBrien Meyer
Director



UPDATED CANCELLATION POLICY as of August 2016

Our Cancellation Policy recognizes that you may, on occasion, need to cancel an appointment due to circumstances beyond your control -- illness, vacation, emergency, etc. We created a Cancellation Policy which we believe is fair to our families while, at the same time, maintaining our program's integrity and addressing the need of your child and our therapists to maintain a schedule that is consistent and predictable.

- ❖ 80% attendance is required to maintain your time slot. In cases of vacation and summer schedules where you will miss more than one appointment in any given month, your family will be required to give up your time slot. We will reschedule you when you can maintain a consistent weekly scheduled appointment.**
- ❖ We recommend that appointments cancelled ahead of time be made up within 1-2 weeks of the missed appointment to maintain continued progress for your child.**
- ❖ Appointments cancelled with less than 24 hour notice for any reason (vacation, illness, emergency, etc.) may be made up within one week of the cancellation date in order to prevent a missed appointment charge of \$95.00.**
- ❖ A no-show appointment (no prior cancellation received) will not have the option of scheduling a make-up session and will be billed the full \$140.00 fee.**
- ❖ We require two weeks notice prior to stopping therapy. Less than two weeks notice will incur a \$140.00 fee.**

Signature of Parent or Guardian, Date

