

Child's Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Attendance Policy**

Sensational Kids, LLC understands that there are times when families need to cancel therapy

appointments due to illness, conflicting appointments, vacations or other family issues. We request that

families provide at least 24 hours notice when therapy appointments must be cancelled. This will allow time for the therapist to offer the available appointment to other children, or provide them time to meet other job responsibilities.

In order to allow us to meet the needs of all the children seen at SK, we have attendance policies that, if violated, will require the therapist to cancel all schedule appointments. Some possible causes that

may require this action include:

1. Cancellation of 3 appointments with less than 24 hours notice in a 60 day period for any reason.

2. Missing an appointment 2 times in a 60 day period without 24 hour notice or contact with SK.

3. 5 or more cancellations for any reason in a 60 day period.

Any of these attendance issues will result in the following actions:

• Children with regularly scheduled appointments will be removed from any future scheduled times, and

will be required to schedule therapy sessions on a weekly basis as appointments are available. This

probationary period will last 4 weeks beginning with the date of the first appointment scheduled.

• After this period children may resume regular scheduling including scheduling appointments out up

to 4 weeks in advance.

• Any additional attendance issues may result in an increased probation/weekly scheduling period

before regular appointments can be resumed.

If you miss 3 consecutive appointments (without contact or proper notice) your child will be discharged from our therapy services. **Please call the office as soon as you realize that your child will not be able to attend therapy. You may leave a message on voicemail 24 hours a day.**

Parents are expected to be on time for arrival and pick up of their children for appointments. In order to respect the appointments scheduled after your child’s therapy, we request that you pick up your child on time

**Sick Policy**

In order to maintain the health of the staff and other children please do not bring your child if they have hada fever or experienced symptoms that are contagious within a 24-hour period. If your child shows visible signs of illness, their appointment may be rescheduled at the therapist’s discretion.

**Consultation Policy**

We understand the importance of coordinating and communicating with other persons involved in your child’s development. We encourage you to provide us with contact information of other professional(s) working with your child. We are available to speak and/or meet with any professional that you request. These consultations are charged at the rate of an individual session. These include consultations with parents, other professionals and teachers regarding your child’s treatment.

By my signature below, I certify that I have been informed of and understand the above policies.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EDUCATIONAL BACKGROUND**

Child's Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade:\_\_\_\_\_\_\_\_\_\_\_\_

School Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School City, State, Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Teacher’s Name(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Academic Concerns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Insurance and Payment Information**

Child's Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I (or my dependent) have insurance coverage with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I understand that I am financially responsible for all charges whether or not paid by insurance. I

hereby authorize Sensational Kids, LLC., to release all information necessary to secure the

payment of benefits. I authorize the use of this signature on all insurance submissions.

**Assignment of Insurance Benefits**

I authorize direct payment of medical benefits to Sensational Kids, LLC the benefits

referred to herein would be payable to me if I did not make assignment and include major medical insurance. I understand that I am personally responsible to Sensational Kids, LLC forcharges not covered or paid by this assignment.

IMPORTANT:

Please make sure we get a copy of your insurance card and/or ID before you leave your first visit. Sensational Kids, LLC will file claims with up to two insurances on your behalf; you will be responsible for filing any additional claims. You are responsible for understanding your insurance benefits.

**If you have an insurance co-payment it will be collected when you sign in at each visit.**

**Authorization to Disclose Medical Information for Insurance Purposes**

Sensational Kids, LLC is authorized to release any medical information required in the

administering of applications for financial coverage for services required. Sensational Kids, LLC may also send results of evaluations and recommendations to referring physicians and

involved agencies for coordination and continuity of care. I have carefully completed this form and to the best of my knowledge it does not contain any false, incomplete or misleading information.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL POLICY**

**PURPOSE:**

Sensational Kids, LLC (SK) is committed to providing quality and affordable health care to the

patients it serves. We respectfully expect that payment is due by all patients at the time services are rendered.

**POLICY**:

To ensure all patient balances are appropriately billed and collected.

**PROCEDURE:**

The following guidelines are to be followed during the billing and collection process:

**Insurance**:

SK participates in most insurance plans. SK will bill the patient’s insurance company as a courtesy.

Insurance claims will be filed weekly by our billing specialist. The patient’s insurance company may

request patients to supply certain information directly, that is the responsibility of the patient to

comply with their request. The patient is directly responsible for the balance of their claim whether or

not their insurance company pays the claim. The patient’s insurance benefit is a contract between the

patient and the insurance carrier; SK is not a party to that contract. If SK does not participate in a

patient’s insurance plan, SK will bill at the rate of $100.00 per hour for Prompt Payment at the

time of service.

**Referrals**:

It is the patient’s responsibility to get any referral or pre-authorizations prior to the time of their visit

or procedure. If the patient is unable to obtain the authorization at the time of their appointment, they

will need to be rescheduled.

**Co-payments and Deductible**:

All co-payments and deductibles must be paid at the time of service. This arrangement is part of the

patient’s contract with their insurance company. Failure on SK’s staff to collect co-payments and

deductibles from patients can be considered fraud.

**Non-covered Services**:

Some if not all services a patient receives at SK may be non-covered or not considered reasonable or

necessary by insurers. Patients must pay for these services at the time of their visit if applicable.

**Proof of Insurance**:

All patients must complete our patient information form before seeing the therapist. SK must obtain

a copy of the current valid insurance card to provide proof of insurance. If the patient fails to provide

this information in a timely manner, they will be responsible for the balance of their claim.

**Methods of Payments:**

SK accepts payment by cash, and checks.

**Patient Statements**:

Unless other arrangements are approved by SK in writing, the balance of the patient’s statement is due and payable when the statement is issued, and is considered past due if not paid within 30 days of issuance.

**Nonpayment**:

If the patient’s account is past due 90 days or greater and the balance has not been paid in full or a payment arrangement made, the patient could be sent to collections. Until these balances are paid in full, our therapists will only be able to treat these patients on an emergency basis for a previously treated injury or problem. Any allowed visits will require cash or check payment in full at the time of service, unless they have valid insurance. Patients may be terminated due to non-payment.

If a patient has filed bankruptcy in the past, any future visits would need to be paid by cash or check if

the patient does not have valid insurance. If there is a valid insurance, any co-payments or deductibles would still need to be paid at the time of service.

**Divorce**:

In the case of a divorce or separation, the party responsible for the account balance is the parent authorizing treatment for a child. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the authorizing parent’s responsibility to collect from the other parent.

**Personal Injury**:

Patient’s that are being treated as part of a personal injury lawsuit or claim, PTC requires verification from their attorney prior to their initial visit if applicable. Payment of the bill remains the patient’s responsibility. SK cannot bill the patient’s attorney for charges incurred due to a personal injury case.

**Medical Records Copies:**

If you require our office to provide a copy of your medical records, you must sign a Medical Records Release of Information form and a copying fee of $10.00 will be required.

**Returned Checks:**

A $35.00 service fee will be added to all checks returned for insufficient funds. If your check is returned, you will be required to pre-pay all future services in full by cash

.

**Credit Balance Refunds:**

SK will make a good faith effort to capture all accounts which have been overpaid

by a patient or insurance carrier and to refund the appropriate party within a reasonable time frame.

A refund will be issued when:

  A patient paid more than was required based on their contractual agreement with their insurance carrier, and there is no other outstanding balance due by that patient to apply the credit to.

 A patient or insurance carrier erroneously issues a duplicate payment.

 The payer erroneously remits payment to the wrong provider.

 The payer originally remits payment for a service that is later determined to be a non-covered service. In this situation, a refund may need to be issued to the payer, and a bill issued to the patient if said non-covered service is deemed by their insurance plan to be a patient responsibility.

 The patient paid an assessed co-pay / co-insurance / deductible and it was later determined that a

 secondary insurance carrier was responsible for this balance.

Refunds will be issued:

 Monthly, upon review of the accounts receivable aging detail credit balance report.

 􀂃 Via company check, payable to the patient or insurance carrier.

**Payment Plan Agreement:**

If the patient is a self-pay patient with no valid insurance coverage a 20% discount will be given to Prompt Pay balances paid in full at the time of service.

**All patient balances are expected to be paid in full at time of service or 30 days upon receipt of patient statement.**

**If the full payment cannot be made, please speak with us about a Payment Plan Agreement.**

Notice of Privacy Policies and Practices

This notice describes how therapy and medical information about your child may be used, disclosed and how you can get access to your child’s information. Please review it carefully.

**I. Uses and Disclosures for Treatment, Payment and Health Care Operations**

Sensational Kids, LLC may use or disclose your protected health information (PHI), for treatment,

payment, and health care operation purposes with your consent. To help clarify these terms, here are some definitions:

 “PHI” refers to information in your child’s health record that could identify him/her.

 “Treatment, Payment, and Health Care Operations”

**Treatment** is when we provide, coordinate, or manage your child’s health care and other services related to your child’s health care.

Example: Your child’s therapist consults with another health care provider, such as

your child’s family physician or other health care professional.

**Payment** is when we obtain reimbursement for your services.

Example: Your child’s PHI is disclosed to your health insurance to obtain reimbursement of your child’s therapy or to determine eligibility and coverage.

**Health Care Operations** are activities that relate to the performance and operation of this practice.

Example: Quality assessment and improvement activities, business related matters

such as audits, administrative services, case management and care coordination.

• “Use” applies only to activities within the practice group, such as sharing, employing, applying,

utilizing, examining and analyzing information that identifies your child.

• “Disclosure” applies to activities outside of the practice group, such as releasing, transferring,

or providing access to information about your child to other parties.

II. Uses and Disclosures with Neither Consent or Authorization

Sensational Kids, LLC may use or disclose PHI without your consent or authorization in the following circumstances:

**Child Abuse**: If SK knows, or has reasonable cause to suspect, that a child is abused, abandoned, or

neglected by a parent, legal custodian, caregiver, or other person responsible for the child’s welfare,

the law requires such knowledge or suspicion to be reported to the Wyoming Department of Health

and Human Services.

**Health Oversight:** If a complaint is filed against SK with the Wyoming Department of Health and

Human Services on behalf of any professional Board, the Department has the authority to subpoena

confidential therapy information from us relevant to that complaint.

**Judicial or Administrative Proceedings:** If you are involved in court proceedings and a request is

made for information about your child’s diagnosis or treatment records thereof, such information is

privileged under state law and will not be released without the written authorization of you or your

legal representative, or a subpoena of which you have been properly notified and you have failed to

inform us that you are opposing the subpoena or a court order. The privilege does not apply when

your child is being evaluated for a third party or where the evaluation is court ordered. You will be

informed if this is the case.

**III. Patient’s Rights and Therapist’ s Duties**

**Patient’s Rights**:

**Right to Request Restriction:** You have the right to request restrictions on certain uses and disclosures of protected health information about your child. However SK is not required to agree to a restriction you request.

**Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, upon your request, SK will send your bills to another address.

**Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI in your

child’s therapy and billing records used to make decisions about you for as long as the PHI is

maintained in the record.

**Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is

maintained in the record. SK has the right to deny your request. At your request, we will discuss with

you the details of the amendment process.

**Right to Accounting:** You generally have the right to receive an accounting of disclosures of your

child’s PHI. At your request, details of the accounting process will be discussed with you.

**Right to a Paper Copy:** You have the right to a paper copy of this Notice from SK, upon request.

**Therapist’s Duties:** The law requires SK to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.

SK reserves the right to change the privacy policies and practices described in this Notice. Unless you

are notified of such changes, however, we are required to abide by the terms currently in effect.

If these policies and procedures are revised, you will be notified in person or by mail.

**IV. Complaints**

If you are concerned that your child’s privacy rights have been violated, or you disagree with a decision made about your child’s records, you may contact SK. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. You will be provided with the appropriate address upon request.

**V. Effective Date** of Privacy Policy: This notice will go into effect February 15, 2010

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Child’s Name

Occupational Therapy and Occupational Therapy Assistant Student Fieldwork

In an effort to promote the field of Occupational Therapy, Sensational Kids, LLC will be accepting students for Level 1 and Level 2 Fieldwork. Level 1 Fieldwork is one week and is designed to give the student an overview of the therapy clinic and is mostly observational. The student will have continuous supervision by an Occupational or Speech Therapist and/or Certified Occupational Therapy Assistant with minimal hands-on contact. During a Level 2 Fieldwork, the student will work directly under an Occupational Therapist. These experiences are eight to twelve weeks. As the student shows readiness, he/she will be allowed to be more independent with treatment but will still be under the supervision of an Occupational Therapist. These students have been educated in all aspects of HIPPA as it relates to confidentiality.

In addition, we may periodically allow a student who is in a pre-occupational therapy program or occupational therapy assistant program to observe. These students must have job shadowing hours in order to apply for occupational therapy programs or complete an occupational therapy assistant program. In this case, there will be no hands on contact with your child and minimal exchange of information.

Your signature below indicates that you have been informed of the possibility of a student being in contact with your child and that you consent to such contact.

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Parent Name (Printed)

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Parent Signature

If you do not want your child to have contact with a student please indicate by signing below.

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

Parent Signature