Apple Tree Therapy, LLC
Jackie Brown, DrOT, OTR/L
Pediatric Occupational Therapist
9951 Mickelberry Rd NW, Suite 123
Silverdale, WA 98383
360-286-2351

PATIENT AGREEMENT

Child's First Name:_____Middle Initial:_____Last Name_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

We are required by federal and state laws to maintain the privacy of your child's 'Protected Health Information', PHI. Your signature below indicates you have received a copy of the 'Notice of Privacy Practices and Your Rights", which describes how health care information about your child may be collected, used and disclosed for purposes of treatment or payment or for other specified purposes that are permitted and required by law. This notice also details how you may access this information.

Parent/Legal Guardian's Signature: _____ Date: _____

CONSENT FOR TREATMENT

I consent that my child receives treatment for occupational therapy services at Apple Tree Therapy, LLC. I understand that treatment usually involves the use of specialized equipment such as suspended equipment, swings, bolsters, inflated equipment, climbing equipment, tactile media, fine and gross motor coordination activities. Therapy activities often involve encouraging the child to try new things in ways that are challenging in order to increase skills and abilities. While Apple Tree Therapy, LLC staff makes great efforts to ensure my child's safety, the nature of the therapeutic intervention includes risk of falling, bumping into other people/equipment and pulling/straining muscles. I understand the inherent risk of this type of activity and I give permission for my child to participate in therapy as described.

Parent/Legal Guardian's Signature: _____ Date: _____

INSURANCE AUTHORIZATION, WAIVER and AGREEMENT

1. I give Apple Tree Therapy, LLC permission to submit bills directly to the insurance carrier on my behalf.
2. I hereby authorize payment of insurance benefits to be paid directly to Apple Tree Therapy, LLC
3. I agree to pay my portion of the insurance deductible directly to Apple Tree Therapy, LLC
4. I understand it is my responsibility to verify insurance eligibility and/or benefits with my insurance carrier and plan.
5. I understand it is my responsibility to confirm that Apple Tree Therapy, LLC is a contracted provider with my insurance carrier and plan.
6. I understand I am responsible to obtain a physician referral and an insurance authorization if necessary. I agree to keep track of the number of visits used relative to those authorized, the expiration date of any authorization and/or the contract limitations of my insurance plan, if needed.
7. I understand that my insurance company may not consider the occupational therapy services provided by Apple Tree Therapy, LLC to be a covered medical expense and payment is not guaranteed.
8. I consent to the release of information requested by my insurance company regarding payment.
9. I understand that if my insurance company does not allow benefits or approve payment of claims for services my child has received, I am responsible for all incurred charges and I agree to pay the balance in full.
10. I understand it is my responsibility to notify Apple Tree Therapy, LLC within 30 days of the effective date if there is a change to my insurance coverage.
11. I understand Apple Tree Therapy, LLC is not contracted with the Department of Social and Health Services (DSHS) to accept Medicaid benefits. I understand that all services provided by Apple Tree Therapy, LLC are not covered by DSHS medical assistance programs and are not included as part of another service. I choose to receive services from Apple Tree Therapy, LLC and agree to pay for the services. Therefore, if my child is covered by DSHS Medical Coupons then I understand that alternate funding is necessary for any services received from Apple Tree Therapy, LLC.

Parent/Legal Guardian's Signature: _____ Date: _____

FINANCIAL AGREEMENT

1. I understand I am responsible for payment of the account in full and am responsible to guarantee that the account is paid in a timely manner.
2. Should collections become necessary, I agree to pay all collection agency fees.
3. Any checks returned NSF will incur a $35.00 fee.
4. Accounts that are past due will incur a finance charge at the rate of 10% monthly past 90 days without payment.
5. The initial evaluation consists of 2 diagnostic observation sessions and 1 parent feedback session for a total of $440.00. Regular ongoing treatment appointments are billed at $176.00 per 55 minute session, and $88.00 per 25 minute session. I agree to pay for the evaluation and treatment sessions provided.
6. I understand I am financially responsible and agree to pay any late arrival, late cancellation, and/or "no call/ no show" charges incurred (see next page for details)
7. Payment is due at the time service is rendered. We accept cash and major credit cards for your convenience.

Parent/Legal Guardian's Signature: _____ Date: _____

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PATIENT AGREEMENT (continued)

Child's First Name:_____ Middle Initial:_____ Last Name_____

ATTENDANCE/ CANCELLATION POLICY

1. I understand there will not be reminders for routinely scheduled appointments. It is understood that your appointment time is typically reserved for you on the same day and time each week.
2. If you must cancel or reschedule an appointment please contact your therapist via voice mail available 24 hours a day at (360) 286-2351.
3. A session delayed 10 minutes or more due to a late arrival or late pick up of the client will result in a $20.00 late arrival charge. *Note: Insurance companies DO NOT reimburse for late fees, therefore I understand I as the responsible party will be held financially responsible and agree to pay this fee.*
4. If you must cancel an appointment, 24 hour notice is required. Understanding that emergencies do occur, it is the policy of Apple Tree Therapy, LLC that a cancellation with less than 24 hours notice will result in a $30.00 late cancellation charge. *Note: Insurance companies DO NOT reimburse for late fees, therefore I understand I as the responsible party will be held financially responsible and agree to pay this fee.*
5. A session will be considered a "no call/no show" if the session is cancelled within 1 (one) hour of the appointment time or is missed without any notice from the client, and will result in a $50.00 "no call/no show" charge. *Note: Insurance companies DO NOT reimburse for late fees, therefore I understand I as the responsible party will be held financially responsible and agree to pay this fee.*
6. Two "no call/no show" cancellations, missing more than 30% of the scheduled treatment sessions, or habitual cancellations may result in the loss of a reserved treatment time slot and/or your child being discharged from therapy services at Apple Tree Therapy, LLC.
7. Every effort will be made to notify you in a timely manner when your therapist is ill, on vacation, or attending a continuing education conference.
8. It is the expectation that you will cancel a therapy appointment with 24-hour notice when possible in the event that you or your child has:
    a. a 100 degree or higher temperature.
    b. vomited within the last 24 hours.
    c. severe diarrhea within the last 24 hours.
    d. or is suspected to have a contagious condition, such as, COVID-19, strep throat, chicken pox, measles, conjunctivitis (pink eye), pertussis (whooping cough), or roseola.
    e. If your child is being treated with antibiotics, then he/she needs to be on the antibiotic treatment for at least 24 hours before resuming their regular schedule, including therapy appointments.

Parent/Legal Guardian's Signature: _____ Date: _____

EMERGENCY MEDICAL RELEASE

In the event medical attention is required for your child while on the premises of Apple Tree Therapy, LLC, I hereby give my permission for Apple Tree Therapy, LLC to contact emergency personnel in the event of a medical emergency if I am not present and cannot be contacted. I understand that Apple Tree Therapy, LLC will not be liable for any first aid treatment, medical, hospital care, medications, or surgical procedures rendered pursuant to this consent.

Parent/Legal Guardian's Signature: _____ Date: _____

PHOTO RELEASE

I give permission for the photography/ videotaping of my child to be used for the purposes of treatment, education and/or documentation: □ Yes □ No

I give permission for the photography/ videotaping of my child to be used for training programs, research, and/or publications. □ Yes □ No

I give permission for the photography/ videotaping of my child to be used for brochures, advertising, social media, and/or website. □ Yes □ No

Parent/Legal Guardian's Signature: _____ Date: _____

I have read, understand and accept all of the terms in Apple Tree Therapy, LLC's Patient Agreement.

Parent/Legal Guardian's Signature: _____ Date: _____

Please Print Parent/Legal Guardian Name: _____ Relation to Child: _____