Client's Name:_____

Date:_____

Treatment Agreement

The following is a description of Wild Roots Therapy Services policies and therapy provided by employees. Please read and indicate your agreement to abide by these policies by initialing and signing where indicated. If you have any questions about these policies, please ask a clinic representative before signing.

Scheduling Policies

I understand that if I am a new client to this clinic or am returning after an absence, I will be required to participate in treatment planning during the first month of treatment with our therapist to plan the goals and objectives of treatment.

I understand that a treatment session consists of **50 minutes of direct treatment.** An additional 10 minutes is used for parent consultation (5 minutes) and writing treatment notes and treatment planning (5 minutes).

I understand that additional time needed for consultation can be provided by ending a treatment session 5 to 10 minutes early, by scheduling a meeting with the therapist, or by scheduling a phone consultation. If I desire a longer consultation, I may schedule calls or meetings with my child's therapist. A fee for in-depth phone consultation time (more than 15 minutes) for myself or another professional involved in my child's case will be added to my bill at the treatment rate.

I understand that once a weekly treatment appointment schedule has been determined, this clinic is often unable to accommodate changes for temporary periods of time. When a permanent change in time is needed, I must give as much advance notice as possible for the clinic to attempt to accommodate this request, however it is not guaranteed that the request will be accommodated.

I understand that in order to receive maximal benefit from treatment, it is important for treatment to occur each week. I understand that notification of vacations or family obligations is requested at least two weeks prior to the expected absence.

I understand that the snow day policy is as follows: the clinic is open except in cases of severe weather conditions requiring businesses to close. It is my responsibility to call the clinic to determine whether changes in the scheduled time of treatment are needed and if the opening of the clinic has been delayed. Families may cancel treatment if they do not wish to travel because of poor road conditions. I understand that snow day cancellations will not be charged and that I will not be charged a late cancellation fee.

I understand that services will be discontinued when the client has received the maximum benefit from therapy. This will be determined by the occupational therapist in conjunction with the client, parent, physician, and/or teachers.

I understand that infants and toddlers often need to be accompanied by a parent during treatment.

Siblings or friends of the child may be invited to accompany the client, this will be decided on a case-by-case basis to determine the potential benefit to the client. In the event that additional people in the treatment room pose a distraction, individuals will be asked to wait in the waiting room during treatment sessions. I am welcome to observe my child's treatment session at any time, however I understand that I may be asked to wait outside if my presence causes a distraction.

I understand that I am responsible for waiting with my child in the waiting room until the session begins and for monitoring my child's play in the waiting room. I understand that this clinic prefers I wait during the session so that I am available to watch parts of my child's treatment when appropriate. If I leave during the treatment session, I understand that I am responsible for notifying the therapist indicating the time and destination so that the clinic knows my whereabouts in the event of an emergency. I understand I am responsible for returning for my child 5 minutes before the close of the 50-minute treatment session.

Adolescent Therapy Consent
The purpose of attending occupational therapy is to help you to identify problem areas in your home, work, school, and community life and find ways to improve your independence and success. You may be here because a counselor, family member, doctor, or legal team decided it was a good idea. When we meet I understand that you may not want me to share all that you say with outside adults. Your confidentiality cannot be maintained if:

- *You tell me you want to hurt yourself.*
- *You tell me you want to hurt others.*
- *You tell me you are being abused.*
- *You are involved in the legal system and they request information.*

Mandatory Reporting
There are legal reasons why we have to disclose private healthcare information. There are state and federal laws that indicate when and why we have to break confidentiality. We have a *Duty to Report* if we suspect abuse/neglect. We also have a *Duty to Warn* if clients are a threat to themselves or others.

Services/Fees

Occupational Therapy Services	
Intake Assessment:	$250/hour *
Therapy Session:	$200/hour *
Aquatic Therapy:	$150/session *
*prorated	
Additional Services not billed to or covered by insurance	
NMT Brain Mapping Assessment:	varies
Phone Consultation after 15 minutes:	$5/10 minutes after allotted 15 minutes
Letter Writing:	$50 writing/creating letters
Attending Meetings:	$200/hour

This practice contracts with a confidential medical billing service Queen Bee Billing (406-672-7802). Queen Bee Billings electronically submits all billing claims to your insurance carrier. Each month you will receive a statement from Queen Bee Billing updating you on your status for what you owe, co-pays, unmet deductible, etc. You are responsible for you deductible, coinsurance, and all non covered services. I understand that confidential information including my child's name, diagnosis codes, date of birth, etc. will be provided to the billing service.

This office offers a sliding fee scale for payment should you be eligible. Please speak with us if you are interested. I understand that if I would like to pay in cash for therapy services and not bill insurance I

can chose to do so and charges will reflect a cash savings with invoices sent directly from therapist.

I understand that for sessions canceled with less than 24-hour notice, a cancellation fee of $25 may be charged. I understand that if sessions are canceled with more than 24 hours notice, I will not be charged a cancellation fee.

I understand that if we do not **cancel and do not keep a scheduled appointment,** we will be charged the full fee for the session, and the session cannot be made up. I understand that make-up sessions may occur if the therapist is available.

Court Action/Legal Fees
Clients are strongly discouraged from having their therapist subpoenaed. Even though a client is responsible for the testimony fees it does not mean that our testimony will benefit your case. We can only testify to facts and our opinion.

If you become involved in litigation and an employee of Wild Roots Therapy, PC is requested to participate you will be required to reimburse for all legal/court fees as listed below:

Court Action Fees	
Preparation	$200/hour
Phone calls	$100/hour
Testimony/Deposition	$200/hour
Court Appearance	$200/hour
Therapist Attorney Fees	Full Cost
Therapist Travel Fees	Full Cost

***A*cknowledgment of Risk**
I acknowledge that there is some risk inherent in the use of the therapy equipment at this clinic, and I agree to indemnify and hold Wild Roots Therapy, PC as not responsible for any injuries or other damages occurring to myself or my child or our belongings from the use of therapeutic equipment.

Financial Policies
I have initiated services and understand that I will be billed at the beginning of each month for services provided the previous month. The bill must be paid within 30 days after the bill is issued. All checks are to be made payable to Wild Roots Therapy, PC. If an insurance carrier has authorized direct billing, I understand that my bill will reflect only that amount not covered or authorized, which is due from me. I understand that this clinic cannot wait for payment if reimbursement is delayed. My monthly balance must be paid by the due date.

If my account becomes overdue by 25 days (45 days from invoice date), I understand that Wild Roots Therapy, PC will discontinue therapy until payment is made. I understand that our treatment slot will be maintained for two weeks only following temporary discontinuation. I understand that this clinic may bill my insurance company directly at my request only when all of the proper insurance information is on record in the billing office. It is my responsibility to contact my insurance plan to find out exactly what is required for direct billing. The following information is required in most cases:

- Referral for occupational therapy from primary-care physician

- Prior authorization from the insurance company if prior authorization is necessary for evaluation and/or treatment
- Insurance policy number, contact phone and address

The occupational therapist will assist in obtaining insurance coverage by writing reports and letters to insurance companies.

I understand that progress reports are routinely written a minimum of one time a year or more frequently if desired, and parent treatment planning conferences are scheduled at these times to discuss my child's current abilities and continued therapy needs and to plan future treatment goals and objectives. I understand that the report and the meeting each will be billed at the hourly treatment rate. All other services (such as home visits, school visits, travel, and phone consultation) will be charged at the standard fee per hour for the number of hours utilized. If an outside agency pays for treatment but does not authorize payment of reports or meetings, I understand I will be billed for these separately.

I understand that I need to provide notification of outside meetings or consultations at least three weeks in advance to allow the therapist to prepare and to coordinate meeting dates and times. This does not guarantee that my therapist will be able to attend.

Therapist/Patient Communication and Authorization

There are so many ways to communicate in today's society and our therapists follow HIPPA confidentiality standards to ensure that we are doing our best to protect your information. We use HIPPA secure medical records services, and HIPPA secure email services. Facebook or other social media contacts are not HIPPA secure. Initiating interactions with your therapist on these platforms does not ensure safe exchange of information. Please carefully read the various methods we can contact you:

(_____)TEXT:_____

(_____)EMAIL:_____

(_____)VOICE MAIL:_____

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE CONSENTED TO THESE METHODS OF CONTACT

Signature:_____ Date:_____

Receipts and Acknowledge of Notice HIPPA

I acknowledge that I have reviewed the Wild Roots Therapy, PC Notice of Privacy Practices, which provides a description of client information, rights, uses and disclosures. A copy was offered to me. I understand that I have the right to request restricts as to how my private health care information may be used or disclosed but that Wild Roots Therapy, PC is not required to agree to the requests.

_____

initials

Parent/Guardian of Adolescent
(___) I will refrain from asking detailed questions about child's session
(___) I agree not to request records about my adolescent's treatment to honor their privacy and confidentiality.
(___) I understand that I will be informed if information shared indicated potential dangers to child or others. This decision to break confidentiality is at therapist's discretion.

Adolescent Consent
Signing below indicated that you have reviewed the policies described above and understand the limits of confidentiality. If you have questions you can ask your therapist at any time**.**

Minor Signature: _____ Date: _____

Optional Policies
Each of the following policies may be initialed or left blank. If you do not wish to sign any one of the following, your therapist may approach you for permission in the event that a need for any of the unsigned items occurs.

Teaching and Research Activities
I give permission for occupational therapy students to observe my child's therapy and for interns in long-term placement (12 weeks) to work directly with my child. I understand I will be notified prior to each session.

_____
initials

I give permission for photographs/videotapes to be taken of myself or my child for educational and promotional purposes. I understand that any such recordings or photographs will be reviewed by me prior to release. Photographs may appear on social media platforms including Instagram and Facebook. Personal information will not be included with these images but others will see these images and understand that you child is receiving therapy services at Wild Roots Therapy, PC.

_____
Initials

Your signature below states that you have read and understand all of the preceding statements and all documents related to each statement. I agree to enter into a therapeutic relationship with Wild Roots Therapy, PC.

_____ _____
Signature of Client/Guardian/Personal Representative *Date:*

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406-969-1795 (PH) 406-969-1796 (FAX)