Sensory Solutions, LLC
Physical, Speech and Occupational Therapy for Children

Policy & Procedures

- All co-pays are due at the time of service
- Balances on ALL accounts must be **PAID IN FULL** in order to continue therapy services. Please check your balance prior to the therapy session.
- Outstanding balances will be sent to collections and therapy will be discontinued.
- 24 hour **CANCELLATION NOTICE** is appreciated (see cancellation policy)
- 2 or more **NO CALL/NO SHOWS** will forfeit your standing appointment time
- Returned checks will result in a $25 fee due at the time of notification
- We are a **teaching facility** therefore there may be times when a student observes or runs the therapy session. You will be notified before the session begins if a student will be involved in the therapy session.
- Due to insurance liabilities we ask that you be seated in the waiting area until a therapist can lead the patient to a treatment room for therapy.
- Please note that your therapist may advise you to step out of the therapy session or remain in the waiting room during the therapy session to assure your child's optimal performance, establish a trusting relationship, and good rapport with your child.
- We do our very best to begin and end treatment sessions on time. Please be prompt for appointments for they will end 40 minutes from the start of your scheduled appointment time. If you choose to drop off your child for therapy make certain you have filled out the Emergency Contact form and arrive 10 minutes prior to the end of your child's session
- Authorization is **not a guarantee of payment**. If your insurance company denies payment you will be responsible for the entire balance.
- We reserve the right to discontinue therapy services if we feel our staff, other patients, and/or your child are at risk for injury or physical harm, due to **aggressive behaviors** before, during, and/or after therapy sessions. When appropriate, we will offer a one time warning before discontinuing services. Aggressive behaviors include, but are not limited to, hitting, kicking, biting, punching, shoving, hair pulling, inappropriate language, and destruction of property.

By signing this document, I acknowledge that I have read and agree to everything listed in the above policy and procedures.

Signature____Date_______________

Corporate Office
10560 Old Olive St. Rd. Suite 100, Creve Coeur, MO 63141
314.567.4707 314.567.4505 - fax

www.sensorysolutions.org

CLIENT FINANCIAL RESPONSIBILITY & CANCELLATION POLICY

It is important to discuss with our clients our financial policy so we may provide the best services for your child. Sensory Solutions, LLC is one of the only private therapy companies that allow families to bill services through their insurance. In taking on this additional responsibility, it is critical that families do their part to ensure that the services being provided for their child are being paid and therapists time being respected.

Deductibles need to be met at the beginning of each fiscal year by major insurance companies. Families are responsible for paying their deductible up front. Families need to pay all deductible payments and co/pays prior to the beginning of their child's therapy session. All bills must be paid prior to each therapy session. If bills become delinquent, therapy will be terminated immediately. If payment is not received, the case will be turned over to our company attorney for collections.

We allow "standing" appointments to our clients to assist with your schedule and ours. In doing this, we will respect your appointment time and will ensure that a therapist will be available if your particular therapist is sick or on vacation. To reciprocate that respect, we ask that you be 5 minutes early to your appointments. If you are late, it takes from your child's session. Each session is 40 minutes in duration so please try and arrive on time. We also ask that you respect our cancellation policy. We are here each and every day to provide a service and need your child here in order to treat him/her and make the most progress possible. It is our experience that children progress toward their therapy goals when there is consistent attendance.

CANCELLATION/ MAKE UP POLICY:

For clients being seen once per week, there will be TWO allowed cancellations per year. For clients being seen twice per week, there will be FOUR allowed. Any other cancellations are subject to our make- up policy. You will be billed (not insurance) for the cancelled session at the rate your insurance company reimburses. You will be allowed to make up this visit and will be credited the amount paid. You will not be reimbursed until the end of your make up session. If you know in advance you will be missing certain sessions (winter break, spring break, vacation) please try to schedule those make up sessions in advance. In case of long-term injury or illness, cases will be dealt with on an individual basis. Cancellations for days the clinic is closed will not be billed.
This policy includes those that are scheduled for a group session as well.

NO SHOWS:

If you have not canceled a regularly scheduled appointment or scheduled a make-up session and still do not come, you are considered a "no show" and you will be billed for your session. "No show" sessions are not subject to our make-up policy

Name: ____ Date: _________________________________

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CONFIDENTIALITY POLICY

At Sensory Solutions, LLC we are committed to maintaining client confidentiality. However, due to space constraints, we are unable to meet with each of our clients families in a private area at the end of each session. Therefore, we use the waiting area to provide you with information about your child's therapy session and home recommendations. We understand that you may prefer an alternative arrangement. If so, please let us know and we will accommodate you. If you prefer, you can schedule a meeting or phone consult with your child's therapist every 1-2 months in place of one of your child's sessions or in addition to his/ her session. Please understand that this visit will be billed privately to the family, not billed through insurance.

Child's name: ____

Parent's name: _______________________________________

_____ I DO GIVE permission for my child's therapist at Sensory Solutions, LLC to discuss and share verbal and/or written information about my child in the public waiting room at the end of each session.

_____ I DO NOT GIVE permission for my child's therapist at Sensory Solutions, LLC to discuss and share verbal and/ or written information about my child in the public waiting room at the end of each session. I will schedule a meeting or phone consult with my child's therapist every 1-2 months to discuss my child's therapy sessions. I understand that I will be billed for this meeting and that I may schedule this in lieu of a session. This will be billed as a private visit, not an insurance visit.

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EMERGENCY CONTACT:

Child: ______________________________ Birthdate:_____________ Phone: (__)____________

Address: _________________________________ Zip: ____________ Email: _________________________

Parent Name (1)_____________________________ Cell: ______________________________

Parent Name (2) _____________________________ Cell: ______________________________

Caregiver's Name________________________________ Cell:___________________________

Two people we can reach in case of emergency:

Name: ___________________________________ Relationship: ____________ Phone: ________________

Name: ___________________________________ Relationship:_______________ Phone:________________

Conditions that might require Immediate or Emergency Care
(Diabetes, food allergies, epilepsy, etc.)

1. _______________________________ Treatment ____

2. ________________________________ Treatment____

I accept responsibility for any necessary expense incurred in the medical treatment of my child which is not covered by the following:

Insurance co. ____ Policy No._________________________

Parent's signature: _______________________________________ Date _________________________________

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