My Pediatric O.T Services' Policies

Client's Name: _____

Please read and then initial

I am agreeing to return all requested paperwork to My Pediatric O.T. Services @ 1776 Washington Street in Walpole, MA, 02081, within 10 days of my referral (fax or email is an option; Fax # 508-337-8438). This will enable us to move forward with the scheduling process.

Initial _____

A $75 deposit is required upon initial evaluation appointment. This deposit can be applied to my out-of-pocket (non insurance, non-billable) costs and/or *optional* full form evaluation report - $325.00 or shorter evaluation summary - $150 (effective July 1, 2022). Deposits can be collected via check or credit card – please check the option that you'd like to use, below. All payments to My Pediatric OT can be made with a credit card on file but weekly payments with a check is also an option and actually preferred.

□ I am mailing a $75.00 check made payable to My Pediatric O.T. services along with this form.
□ I would like the $75.00 deposit to be charged to my credit card, as listed on the submitted credit card authorization form **Initial _____**

This deposit may also be applied towards our cancellation policy ($75.00 fee) if an appointment is ***canceled with less than 12 hours notification or failing to show up to your scheduled appointment****.* **Initial _____**

Although we do understand exceptions may apply, especially in the case of children, treatment sessions need to be canceled a minimum of ***12 hours prior*** to the appointment in order to avoid a $75.00 cancellation fee.

Initial _____

I understand that if I *opt* for a full form written evaluation report, it will be available 3 – 4 weeks after the evaluation session(s). The *balance* due for the *optional report* will cover the therapist's time (insurance companies cover time with the child administering the evaluation but *do not* reimburse time scoring and writing the report which takes an average of 2.5 to 3 additional hours to complete).

□ ***I am interested*** in having an evaluation report completed for my child. **Initial _____**
□ ***I am <u>not</u> interested*** in having an evaluation report completed for my child. **Initial _____**
I understand an ***additional fee*** will apply towards certain administration requests.

Although parents are given the option of leaving the building during a session it is expected that you are available for a child who needs toileting assistance and it ***is expected that the caregiver has returned and is available 15-20 minutes prior to end of session.*** **Initial _____**

I understand it is expected that therapy session attendance is consistent as this is most beneficial to your child and ***if cancellations are frequent we will request that you move to a different spot in schedule.***

Initial _____

I understand that a physician's referral may be needed in order to attain authorization for Occupational Therapy services. Prior to my child's appointment, **I am responsible for contacting my insurance company to attain referral/authorization as needed. Any preauthorization number can be emailed to MyOTServices@gmail.com or included in paperwork packet and mailed to the office (pediatrician may fax to 508-337-8438).**

Please contact Julie at MyOTServices@gmail.com with questions regarding the above policies.

Signature: _____ Date: _____

Updated July 1, 2022