BOSTON SENSORY SOLUTIONS

617.691.7140 information@BostonSensorySolutions.com

I, _____, hereby authorize the therapists of Boston Sensory Solutions to evaluate and treat _____ for pediatric occupational/speech therapy.

_____ _____
Parent or Legal Guardian Date

I understand that the patient's protected health information may be used and disclosed to carry out treatment, payment or healthcare operations. For a more complete description of the potential uses and disclosures of the protected health information, please refer to the Notification of Privacy Practices issued on the first day of treatment. If you have misplaced your copy, please feel free to contact our office by email at information@BostonSensorySolutions.com to request that we send one to you via email or US Mail. The Notice of Privacy Practice may change and you have the right to an updated copy. To receive a copy, please contact us. You have a right to review the Notice of Privacy Practices prior to signing this consent. If you have any questions, you may contact our privacy officer at information@BostonSensorySolutions.com or 617.691.7140. Please note that you have the right to request that Boston Sensory Solutions restrict how your protected health information is used or disclosed to carry out treatment, payment or health care operations. It should be noted that the provider is not required to agree to requested restrictions; however, if the provider agrees to a requested restriction, the restriction is binding on the provider. You have a right to revoke the consent in writing, except to the extent that the provider has taken action in reliance on it.

_____ _____
Parent or Legal Guardian Date

I give consent to leave a message on my voicemail system regarding my child and his/her care.

_____ _____
Parent or Legal Guardian Date

I give consent to communicate via e-mail regarding my child and his/her care.

_____ _____
Parent or Legal Guardian Date

I authorize payment of medical benefits and/or government benefits to Boston Sensory Solutions.

_____ _____
Parent or Legal Guardian Date

Notice of Privacy Practices

I, _____, have been issued a copy of Boston Sensory Solutions Notice of Privacy Practices. If there are any questions regarding this notice, I understand that I may contact the privacy officer at 617.691.7140 or via email at information@BostonSensorySolutions.com.

_____ _____
Parent or Legal Guardian Date

Policy regarding Cancellations

In an effort to be respectful of your busy schedule and ours and secondary to the large waiting list and the high demand for therapy services, Boston Sensory Solutions employs an attendance policy for all scheduled therapy appointments. It is as follows:

Planned Cancellations: (doctor's appointment, vacation) • It is the parent's/caregiver's responsibility to keep the therapist informed of any changes needed in a child's scheduled therapy visits. We request a 48-hour notice of any cancellations so that adjustments can be made and make up sessions scheduled if possible. If you cancel a session with less than 48 hours' notice, you will be billed for the full session fee. • Our Therapist will give a minimum of 48-hour notice for any rare cancellations she needs to make with regard to your scheduled visits.

Cancellations Due to Illness: It is important that both the parent/caregiver and therapist be respectful of health concerns. Children with diarrhea, vomiting, contagious diseases, and/or a temperature above 100 degrees should not be seen to ensure the health of your child, the therapist, and other patients being treated. Should your child (or another child in the home who will be there during therapy time) wake up with any of these symptoms, please contact the Clinic as soon as possible. Your therapist will likewise call as soon as possible should she be ill and not be able to render services to your child. Your child should be symptom free for 24 hours before resuming therapy.

"No Shows": In the event of a "no call/ no show" (not showing up at the clinic at the scheduled time without notice), you will be given written notice and charged a full session fee. A second "no show" within a 3-month period will additionally result in the child being discharged from your therapist's caseload. "No shows" are not eligible for rescheduling in lieu of the fee.

Consistent Attendance: Clients must keep at least 75 percent of scheduled therapy visits per month. Clients who are at or below 75% attendance for 2 consecutive months will be given written notice of discharge from therapy services.

I have read and agree to abide by the above attendance policy with regard to cancellations and "no shows" for scheduled therapy visits.

_____ _____

Parent or Legal Guardian Date

Billing Policy and Procedures

1. Payment is due at the time of service. We accept cash, personal check (with a $35 return check fee if applicable), as well as Master Card and Visa.
2. If you have a health insurance for which we are in-network, we will bill your insurance as a courtesy to you. Co-payments are due at the time of service. Deductibles are due at time of insurance processing. It is your responsibility to assist in the prompt receipt of payment from your insurance company, at our request.
3. You must immediately inform Boston Sensory Solutions of any changes in your insurance. Failure to notify us of changes will result in parent or legal guardian being responsible for payment.
4. Any fee that is not paid at time of service may results in an inability for future appointments to be made. Any fee not paid within 30 days of date of service will result in discharge form therapy. Any fee not paid within 90 days of date of service will be turned over to collections.
5. If you need special assistance to pay your portion of therapy charges, please don't hesitate to call our office. We may be able to develop a payment plan to assist you.
6. I authorize Boston Sensory Services to bill me for services via email.

I understand and accept the billing policies and procedures listed above.

_____ _____

Parent or Legal Guardian Date