



Children's Therapy Center, Inc.

Patient Service Email Agreement

Child's Name: _____

DOB: _____

1. It is the patient/parents(s)/guardian responsibility to inform Children's Therapy Center, Inc. (CTC) of any and all changes in insurance information, including group policy number, identification number, phone numbers, addresses, etc. as soon as possible. **Failure to do this could result in total patient responsibility for charges incurred.**
2. **Cancellation Policy** – We are committed to providing quality consistent services to our clients. Therapy will be most beneficial to your child with **consistent attendance**. It is also important that you **arrive on time** so that your child can benefit from a full session. Routine tardiness may result in billing that time directly to you. We understand that there will be unavoidable circumstances that may come up. **In order for us to plan appropriately for staff, we require that parents call to cancel their appointment for illness or an unavoidable conflict as soon as possible. We reserve the right to charge a fee of \$50.00 for missed unexcused absences and \$25.00 for arriving 10 or more minutes late.** Termination of services may occur following three sessions that were not cancelled ahead of time or following routine/regular cancellations. When possible, we will try to reschedule your appointment that week. There are many families that are waiting for services. We appreciate your cooperation with this.
3. For your convenience, Children's Therapy Center, Inc. allows parents/legal guardians or caregiver to leave the premises during their child's appointment. However, it is very important to be back on the premises 15 minutes before the patient's appointment is scheduled to end so the therapist can discuss treatment with the parent/legal guardian or caregiver. If Children's Therapy Center, Inc. notices chronic tardiness in picking up children, we will begin asking the parent/legal guardian or caregiver to stay during the patient's treatment. Children's Therapy Center, Inc. must have a cell phone number to reach you before leaving.
4. Additionally, Children's Therapy Center, Inc. realizes the parent/legal guardian or caregiver's time is important, and it is our sincere intention to honor all appointment times. On occasion, a delay or emergency will occur. For this reason, we may need to delay or reschedule the patient's appointment. If this occurs, notification will be given as early as possible. To expedite this process, we ask the parent/legal guardian/caregiver to provide us with a daytime telephone number for notification purposes.
5. **Out of pocket policy:** Insurance policies are contracts made between the patient and the insurance company. When insurance does not provide payment of therapy costs, payment of the bill is your responsibility. If for any reason treatment is denied by your insurance, we will charge for the usual and customary amount paid by your insurance company.
6. **Consent to release photo of your child:** We like to display pictures of the children who come to CTC. Please initial if it is ok for CTC to display pictures of your child (names will not be used without additional approval) in our brochure, website, advertisement/promotional activity and/or in our clinic.

_____ Initial that you have read and agree to #6

7. For your benefit and to insure the highest level of coverage from your insurance company, we choose to participate in most insurance plans, which results in lower payments to the provider but lower costs to the patient. Both private insurers and the Federal Government prohibit waiving and/or reducing the co-payments. Due to binding contracts with each insurance company and industry wide standard ethics, we are required to collect all co-payments and deductibles that are due by your specific policy. We are obligated to be in compliance with these standards.
8. **Information regarding child's therapy session may be discussed in the office waiting area with others present. You have the right at any time to request that this happen in a private room. This request must be made verbally to the therapist at the time of discussion.**

Parent/Legal Guardian's Signature

Date (MM/DD/YYYY)

By entering your complete name and emailing this form it will be considered signed by you.

You may be asked to sign the form in person on your first visit. Thank you for your cooperation.

You may email the completed forms to: info@childrenstherapyctr.com

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