Kids Place
THERAPY SERVICES, LLC

PATIENT SERVICE AGREEMENT

INITIAL:

1. Our fees for services are billed on a monthly basis. The statement will contain a complete itemization of charges and will reflect payments to date. All charges are due and payable within 30 days of receipt. Please notify us promptly if you have a change in insurance coverage. _____

2. Kids Place Therapy Services, LLC will file insurance claims based on the information provided. The parent or guardian is responsible for all co-payments, co-insurance and deductibles. If the insurance program denies payment, the parent or guardian is fully responsible for the payment. All outstanding balances are due within 30 days. Any amounts not paid will be charged an additional 1% interest per month (up to 12% per year) on balances greater than 90 days. If, for any reason, your account is referred to our collection agency, you will be responsible for all collection costs, court costs and reasonable attorney's fees. A $35.00 charge will be added to the account for each returned check. We accept credit card payments. A 3% credit card processing fee will be added to your total bill _____

3. Should financial hardship arise, the client's family should contact Kids Place Therapy Services, LLC immediately to arrange a satisfactory means for addressing the obligation. It is understood that Kids Place Therapy Services, LLC, with proper notice, will suspend services at any time if determined that satisfactory progress is not being made to retire outstanding debt. _____

4. If the situation arises that the participant is in need of first aid or emergency medical treatment, the signer of this agreement authorizes agents of Kids Place Therapy Services, LLC to seek and secure medical attention. The parent or guardian agrees to pay all fees and costs arising from this action to obtain and deliver medical treatment. _____

5. As a courtesy, Kids Place Therapy Services, LLC may, in some cases, allow the parent, guardian or caregiver to leave the premises during the child's appointment. The treating therapist will make this determination. If leaving the premises, it is necessary that you leave your cell phone number in case you are needed back before the end of the session. Also, you must return 10 minutes before the end of the session so that the therapist can discuss the child's treatment with you. _____

6. Children cannot be left unattended in the waiting room. All children must be accompanied by a parent/guardian or responsible party in the waiting area prior to and after each therapy session. For safety reasons, children will not be permitted to leave the clinic to wait at the door for their ride. _____

7. Health Policy: If your child is sick and/or contagious within 24 hours of the scheduled appointment, please keep your child at home. If prescription medication is required for treatment of illness, your child must receive the medication for 24 hours prior to the scheduled session. In case of illness, please call to cancel the appointment as soon as possible. _____

8. Consistent attendance at scheduled therapy sessions is necessary to make progress and meet the goals of therapy. Kids Place Therapy Services, LLC has a 24 hour cancellation/rescheduling policy. If you miss, cancel or change an appointment with less than 24 hours notice, you will be charged $45. This policy is in place out of respect for our therapists and clients. Cancellations with less than 24 hours notice are difficult to fill and prevent others from scheduling. If your child does not regularly attend scheduled sessions, he/she will be removed from services. You will be notified of this via telephone and/or mail. _____

9. The staff at Kids Place Therapy Services, LLC includes licensed therapists as well as therapist assistants. Licensed therapists complete all evaluations and treatment plans. Your child may be seen by a therapist assistant if deemed appropriate by the evaluating therapist. _____

By signing below, you acknowledge that you have read and agree to the terms of the Patient Service Agreement.

SIGNATURE: _____ DATE: _____

Parent/Legal Guardian