NORTHSHORE
pediatric therapy

CLIENT INFORMATION

Child's Legal Name: _____ **Date of Birth:** _____

Child's Preferred Name: _____

Age:_____ **Sex:** _____

Parent(s)/Legal Guardian(s):

Name: _____

DOB:_____

Home Ph.: _____

Cell Ph.: _____

Work Ph.: _____

Best number to reach you at:

_____

Physical Address:

_____

_____

Mailing Address:

_____

_____

Occupation:

_____

Employer:

_____

Name: _____

DOB:_____

Home Ph.: _____

Cell Ph.: _____

Work Ph.: _____

Best number to reach you at:

_____

Physical Address:

_____

_____

Mailing Address:

_____

_____

Occupation:

_____

Employer:

_____

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Who can we thank for referring you to our office? _____

If primary person bringing child to therapy is not listed above, please list name and contact number of that person.

_____

INSURANCE INFORMATION (please fill out ALL areas):

Primary Insurance: _____	**Secondary Insurance: _____**
Policy #: _____	**Policy #: _____**
Group #: _____	**Group #: _____**
Claims Address:	**Claims Address:**
_____	**_____**
_____	**_____**
Phone Number:	**Phone Number:**
_____	**_____**
Insured's Name:	**Insured's Name:**
_____	**_____**
Insured's DOB: _____	**Insured's DOB: _____**

I CERTIFY THAT I DO NOT HAVE ANY OTHER INSURANCE COVERAGE FROM ANY OTHER SOURCE OTHER THAN THAT IDENTIFIED ABOVE. Initial _____

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Payment Policy: Insurance & Private Pay

Thank you for choosing Northshore Pediatric Therapy for your speech-language pathology needs. This is an agreement between Rebecca Cummings, M.S., CCC-SLP, PLLC, d.b.a. Northshore Pediatric Therapy, and you for payment of services provided. By signing this agreement, you are agreeing to pay for all services provided to you or your family member for whom you are legally responsible.

If you plan to have us submit claims to your insurance company, it is recommended that you complete the following before your first appointment:

- Check with your insurance company to find out what speech and language services they will pay for (see attached "Insurance Company Inquiry" form for further information about what questions to ask).
- Find out what information the insurance company needs.
  - You may need a note from your doctor, called a referral. You may need permission from the insurance company, called pre-authorization.
  - Referrals and pre-authorizations do not guarantee that insurance will pay for services.

In-Network:
For clients with Premera, Regence, Blue Cross/Blue Shield, your co-pay will be billed after insurance processes your visit. We will bill your insurance directly and the remaining client responsibility will be billed to the card on file (unless alternate form of payment is specified). If we have not received payment from your insurance carrier within 60 days, you will be responsible for paying your account balance. In the event that we receive payment from your insurance carrier after you have paid, we will refund your payment.

Insurance Disclaimer:
You are responsible for contacting your insurance company to determine benefits for our services. We will provide you with more information on how to request that information from your insurance company. It is important to note that information collected from the insurance companies is a quote and not a guarantee of payment. Benefits, if any, will be assessed by your insurance plan. Upon receipt, claims are subject to eligibility and based on plan provisions and limitations in effect at the time of services rendered. Any and all charges/balances that are not covered by your insurance company are your responsibility to pay.

Services not covered by insurance:

- Consultations
- IEP/school meetings
- Travel to meetings (prorated to each 15 minutes)
- Missed appointments (see cancellation policy below)

These services are billed at the cash rate directly to the client or guardian.

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Private Pay:

Please read the following information carefully.

If you have indicated that you are a **private pay** client, Rebecca Cummings, M.S., CCC-SLP, PLLC, d.b.a. Northshore Pediatric Therapy will not bill insurance companies for evaluations and treatment. We will provide you with the information you need to submit a bill to your insurance company, if requested.

Payment Options:

- All private pay fees are due at the time of service. We accept all major debit/credit cards (Visa, Mastercard, Discover, American Express).
- If paying with debit/credit card, the card on file will be billed on the day of service.
- If you plan to pay with a check, a credit card authorization form must be kept on file and will be charged in the event that check is not available at the time of service, a check is returned, or a session is missed without proper notice (see Cancellation Policy for further details).

Rate:

The current evaluation rate is $300 per evaluation. Therapy sessions are $120 per session. A prompt pay discount of 10% is given for therapy sessions when a card is kept on file. If sessions are less than the scheduled length due to a client's late arrival, the base rate of $120 applies. Northshore Pediatric Therapy reserves the right to change rates at any time.

Returned checks:

- You will be charged a $30 fee for each returned check or declined debit/credit card transaction.
- The credit card on file will be charged for the account balance and the $30 returned check/decline fee.

Past due accounts:

- Accounts thirty (30) days past due will be charged a 20% fee per month until payment is received.
- Accounts two (2) months past due will be sent to a collection agency. You will be responsible for collection costs, as well as attorney fees and court costs.

_____
Client's Name

I agree to the payment policies outlined above.

_____ _____
Client or Parent/Guardian Signature **Date**

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Authorization To Bill Health Insurance/Assignment of Benefits
(This is not applicable for private pay.)

I _____ (print name) do hereby give full permission and authorize Rebecca Cummings, M.S., CCC-SLP, PLLC, d.b.a. Northshore Pediatric Therapy, to bill _____(name of insurance company) for services rendered by Rebecca Cummings, M.S., CCC-SLP, PLLC, d.b.a. Northshore Pediatric Therapy. I also agree to have any checks or payment made by said insurance company to be payable and deliverable to: Northshore Pediatric Therapy (Rebecca Cummings, M.S., CCC-SLP, PLLC). By signing this document I also agree to the following statements below:

I understand that I am responsible for understanding information about my health insurance policy and providing such information to Rebecca Cummings, M.S., CCC-SLP, PLLC, d.b.a. Northshore Pediatric Therapy, for correct billing. I am also responsible to notify Rebecca Cummings, M.S., CCC-SLP, PLLC, d.b.a. Northshore Pediatric Therapy in the case of change of my health insurance status – inclusive benefits and any information I receive relating to care I have or will receive in this office.

I understand that Rebecca Cummings, M.S., CCC-SLP, PLLC, d.b.a. Northshore Pediatric Therapy will be providing services and billing my health insurance for those services at various times during the course of my care at this office. I understand that ultimately I am responsible for all payment(s) relating to any and all charges relating to treatment and services that I have received at Northshore Pediatric Therapy during my care.

_____
Parent/Guardian Signature

_____ _____
Print Name **Date**

In order to bill insurance for services, we must have your child's physician approve the plan of care.

PHYSICIAN NAME:_____
ADDRESS: _____
PHONE: _____
FAX: _____

By signing, I authorize Rebecca Cummings, M.S., CCC-SLP, PLLC, d.b.a. Northshore Pediatric Therapy to release medical records to my child's physician, listed above. I understand that if I choose not to sign this form, I will be personally responsible for all fees for service.

_____ _____
Parent/Guardian Signature **Date**

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Credit Card Charge Authorization Form (REQUIRED)

The undersigned hereby authorizes Rebecca Cummings, M.S., CCC-SLP, PLLC, d.b.a. Northshore Pediatric Therapy to charge the below-referenced credit card for services rendered and any related expenses in accordance with the cardholder agreement. In addition, I understand my credit card will be charged in the event that:

- I do not pay at the time of service.
- Proper cancellation procedures are not followed as noted in the Attendance and Cancellation Policies for initial evaluations and ongoing therapy sessions.
- A check is returned for insufficient funds or credit card declined (fee of $30.00).

At discharge, if an account balance remains, your credit card will be charged for unpaid services to discharge date.

I, the undersigned, further understand it is my responsibility to inform Rebecca Cummings, M.S., CCC-SLP, PLLC, d.b.a. Northshore Pediatric Therapy of any changes to my credit card information including address, zip code, updated expiration dates, account numbers and security codes.

CHOOSE ONE: VISA MASTER CARD DISCOVER AMERICAN EXPRESS

Account No. _____-_____-_____-_____ Expiration Date: _____

Security Code:_____

Name as it appears on Credit Card: _____

Billing Address:_____

BY SIGNING BELOW, I UNDERSTAND THAT THE ABOVE CARD WILL BE CHARGED FOR ALL PAYMENTS OWED TO REBECCA CUMMINGS, M.S., CCC-SLP, PLLC, D.B.A. NORTHSHORE PEDIATRIC THERAPY.

Signature_____ Date_____

THE BELOW OPTION IS NOT AVAILABLE FOR PRIVATE PAY

☐ I **DO NOT** want my card auto-billed for my account balance I would like to pay using:

☐ Check

☐ I would like to be invoiced via Fusion Web Clinic's integrated payment processing and will be responsible for paying manually (this is not an option if you are private pay and want the prompt pay discount)

6443 NE 181st Street | Kenmore, WA 98028 | Phone: (425)419-6199| Fax: (425)407-5508
Email: admin@northshorepediatric.com | www.northshorepediatric.com

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Communication Preferences

I give permission for my child's therapist and/or staff of Northshore Pediatric Therapy to (check one):

Communicate with me regarding therapy sessions (including progress, attendance, scheduling, etc.) via text, email and voicemail.

○ YES ○ NO

Communicate with me via email regarding therapy. Some emails may include PDF attachments and Word documents which may or may not be password protected.

○ YES ○ NO

I understand that:

If I want my child's therapist to communicate with anyone other than the parent/guardian of the child indicated on initial paperwork, I must sign and authorize consent to do so. I will request for Northshore Pediatric Therapy to do so in writing.

Parent/Guardian Initials_____

If a divorce or separation situation exists, a custody agreement and separation agreement will need to be shared with Northshore Pediatric Therapy. I will share custody agreements with my therapist/Northshore Pediatric Therapy to ensure that my therapist only shares information with the legal guardian(s) of my child.

Parent/Guardian Initials_____

My child's invoice for speech services will be emailed, mailed, or provided in person at the next treatment session, if requested. Information containing diagnosis codes, procedures codes, dates of service, and cost of service will be included on these invoices.

Parent/Guardian Initials_____

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CONSENT FOR EVALUATION AND/OR THERAPY

I, _____(parent/caregiver),

acting on behalf of _____ (hereinafter referred to as "the Client"),

consent to the necessary care and/or treatment of the Client by the therapists doing business for Northshore Pediatric Therapy. I consent to care and treatment that falls within the scope of speech/language and/or occupational and/or physical therapy practice as defined by the State of Washington, the American Speech-Language-Hearing Association, the American Occupational Therapy Association, and/or the American Physical Therapy Association. I acknowledge that no guarantee has been made to me as the result of evaluation and/or treatment.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE CONTENTS AND AM COMPETENT TO EXECUTE IT OR IF EXECUTED ON BEHALF OF ANOTHER, I AM AUTHORIZED TO EXECUTE IT ON BEHALF OF THAT PERSON.

_____ _____

Signature of Client or person authorized to consent **Date**

Relationship to the Client _____

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ATTENDANCE AND CANCELLATION POLICY

In order to better serve you and make quicker progress towards goals, regular attendance to therapy is imperative. One of the most common causes of lack of progress is inconsistent attendance. Please read and initial next to your responsibilities outlined as follows:

_____ I am responsible for attending sessions as scheduled. I understand that I must maintain at least an 80% attendance rate or risk losing my appointment spot.

_____ In the event of a cancellation, I will provide as much notice as possible.

_____"Non-emergency" cancellations require at least 24 hours' notice and include vacations, pre-planned medical appointments, family events, parties, sports events, lack of childcare, or anything not designated as "emergency". **If the session is not cancelled with 24 hours' notice, I understand that I will be responsible to pay the full session fee of $120.**

_____"Emergency" cancellations are accepted only for illness (fever within the last 24 hours, strep, unidentified rash, diarrhea, vomiting, or any highly contagious illness), illness of a family member, or death in the family. In the event of an emergency cancellation, I understand I still must notify the clinic by 9am on the day of the appointment to avoid a "no show" fee equal to the full amount of the session, as outlined above ($120).

_____ Inclement Weather: In the event of an expected storm or dangerous roads, the office typically closes. It is noted that if the office is open despite inclement weather, you may choose to stay home with your child without charge. In this case you must follow the procedure for EMERGENCY cancellations, and call by 9am that day if it is unsafe for you to travel. If notification is not received by 9am, you will be billed the full amount of the session.

_____ I understand that Rebecca Cummings, M.S., CCC-SLP, PLLC, d.b.a. Northshore Pediatric Therapy may send me an email or text reminder the day before my scheduled appointment, as a courtesy. I recognize that my attendance is not dependent upon the receipt of an email or text reminder.

The email below is my preferred email for receiving courtesy appointment reminders:

Email: _____

I have read, understand, and agree to Rebecca Cummings, M.S., CCC-SLP, PLLC, d.b.a. Northshore Pediatric Therapy's Attendance and Cancellation Policy as outlined above.

Signature: _____ Printed Name: _____

If signing as a parent or guardian:

Name of Client: _____ Relationship to Client:_____

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RELEASE FORM (optional)

Photographic Images

I give permission to Rebecca Cummings, M.S., CCC-SLP, PLLC, d.b.a. Northshore Pediatric Therapy to take and use photographic images for the following purposes (check all that apply):

☐ Training and/or educational purposes

☐ Use in marketing materials

☐ Inclusion on the Northshore Pediatric Therapy Facebook page and/or website

Audio Recordings

I give my permission to Rebecca Cummings, M.S., CCC-SLP, PLLC, d.b.a. Northshore Pediatric Therapy to take and use audio recordings for the following purposes (check all that apply):

☐ Therapy tool, for client feedback

☐ Training and/or educational purposes

Video Recordings

I give my permission to Rebecca Cummings, M.S., CCC-SLP, PLLC, d.b.a. Northshore Pediatric Therapy to take and use video recordings for the following purposes (check all that apply):

☐ Therapy tool, for client feedback

☐ Training and/or educational purposes

☐ Use in marketing materials

☐ Inclusion on the Northshore Pediatric Therapy Facebook page and/or website

Signature: _____ **Date:**_____

If signing as a parent or guardian,

Name of Client: _____ **Relationship to Client:** _____