WELCOME!

Dear parent(s):

We are honored that you chose Village Pathways Comprehensive Therapy as a partner in your child's development. As a team, we must work together to facilitate your child's development and maintain their safety when they are in their therapeutic environment.

In an effort to maintain a SAFE and professional environment at our clinic, we are requesting that you keep a watchful eye on your child or children at all times. In order to continue services here at Village Pathways Comprehensive Therapy, LLC, the following guidelines must be strictly adhere to:

- No running in the parking lot or lobby area as this poses a safety hazard due to flow of traffic.
- Refrain from climbing on the metal rail(s) to prevent accidental falls and possible bodily injury.
- The landscape is professionally maintained; therefore we are not aware of the chemicals that may be harmful to your child.
- Do not park in parking spaces that are reserved; park only in available spaces.
- Loitering is prohibited.
- Please dispose of all trash in the proper receptacles.

Thank you in advance for your cooperation.

By signing below, you indicate that you understand the terms outlined above. Thank you for your commitment to your child's therapy.

_____ _____

Patient's Name Parent/Guardian Signature

_____ _____

Therapist/Office Manager Date

Explanation of Services and Fees for Services

Once you have signed the **Permission for Evaluation and Treatment** form, an assessment will be conducted for physical therapy services only. Your child's skills will be assessed using a norm-referenced standardized measure. Upon completion of the testing, you will be notified or recommendations for your child to receive physical therapy through an evaluation report. You may be called by the clinic to obtain any previous medical history that will be included in the report.

Services will only be delivered if there is a delay in gross/fine motor skills. If there are other developmental or medical concerns present, you will be informed and recommendations made for further assistance.

Fees for services will be billed to Medicaid, CMO's (e.g. PeachState, Amerigroup), insurance carriers (e.g. Blue Cross Blue Shield, Cigna), or the family (private payment). If Village Pathways Comprehensive Therapy is not covered by the child's insurance carrier, the clinic will receive private payment or refer the child to local clinics that carry his/her insurance. You (parent/guardian) are responsible for payment if any fees are not covered by Medicaid, CMO's, or private insurance.

Please check one of the following:

- ☐ My child has Medicaid under a CMO, or private insurance and I give permission to Village Pathways Comprehensive Therapy to bill child's payment source for assessment and treatment.
- ☐ My child does not have Medicaid under a CMO or private insurance, and I would like recommendations and assistance with obtaining services for my child.
- ☐ I do not want my child to be evaluated at this time.

_____ _____

Child's Name Parent/ Guardian Signature

_____

Date

Permission for Evaluation and Treatment

I, _____ (Parent/Guardian), give Village Pathways Comprehensive Therapy, permission to evaluate and treat _____ (Child's Name & Date of Birth). I know that all records will remain confidential and will not be released without my permission and signed consent. I understand that I have the right to review all records pertaining to his/her care at my request.

_____ _____
Parent/Guardian Signature Date

_____ _____
Therapist Signature Date

Please complete the following information:

_____
Address

_____
Home/Cell Phone Number

_____
Work Phone Number

_____
Email Address

ATTENDANCE POLICY

Thank you for choosing **Village Pathways Comprehensive Therapy** for your child's care. The policies written below are designed to improve our ability to see all of our clients and to provide complete, consistent treatment for your child. We hope these policies will improve our overall service to our families. Since continuity of care is important to maximize the outcomes of your child's therapy, we use the following guidelines for your child's appointments:

1. Therapists often are not able to wait more than 15 minutes for a late appointment. **Please notify your therapist as soon as you know you are going to be late.** Because of scheduling constraints, late arrivals may not be able to be seen, and if seen, the session will end at the regularly scheduled time.

2. **24-hours or more** advanced notice for all cancelled appointments is **mandatory**. If you need to cancel your child's appointment, our clinic requires that you cancel 24 hours in advance of the scheduled appointment time. You will be charged **$20.00 (not your insurance)** except in an emergency situation for the scheduled therapy appointment that was missed. **In the event of an emergency, the cancelled session must be rescheduled within a week.**

3. If you have **three** cancellations within a **2 month period** or you miss **more than half** of your scheduled appointments within **the quarter**, you may lose your standing appointment time slot. Additionally, your child may be placed on hold for therapy. You will be notified by phone or letter should this occur. If removal from the schedule should occur, in order to be placed back on the schedule, a mandatory meeting, or telephone conference between the family, the therapist, and Clinic Director will be required.

4. **"NO-SHOWS" ARE UNACCEPTABLE**. If you do not attend your scheduled appointment and you have not called to give any type of notification that the session was going to be missed, you be considered to be a "No Show" for that appointment. **Please note that a telephone call after the appointment does not constitute notification and will be considered a "No Show".** Additionally, a **$20.00 (not your insurance)** penalty fee will be assessed. If you have **two "No Shows"** for scheduled appointments, in addition to the penalty fee, you will lose your standing appointment time slot and your child will be dismissed from therapy. You will be notified by phone or letter should this occur.

5. **Irregular attendance may affect your future insurance benefits for therapy services.**

Please sign below. By signing, you indicate that you understand the terms outlined above. Thank you for your commitment to your child's therapy.

_____	_____
Patient's Name	**Parent/Guardian Signature**
_____	_____
Therapist/ Office Manager	**Date**

CONSENT & AUTHORIZATION TO RELEASE INFORMATION

If there are other parties that may assist in your child's treatment, and you believe it would be helpful for your therapist to contact them regarding your child's treatment, please read carefully and complete this document.

The following is an authorization for the stated parties to consult with one another regarding your child's treatment or assessment process. Information shared is for the sole purpose of facilitating maximum care to your child as the client. Please provide the necessary information and your signature with today's date as indicated below.

****

I, _____ (parent or guardian), hereby authorize _____ (therapist) and the following party or parties to discuss my child's health treatment information and records obtained in the course of therapy treatment or assessment, including, but not limited to, the therapist's diagnosis:

(1) _____

(2) _____

(3) _____

Please note that treatment is not conditioned upon your signing of this authorization, and you have the right to refuse to sign this form.

Please indicate your preference regarding the information to be shared:

_____ The parties stated above may discuss my child's medical and /or mental health information without limitations.

_____ I would prefer to limit the information shared between the parties stated above. The limitations I would like to make are as follows: _____

Additionally, the above named parties, speech therapist & person(s) or entity (entities) designated under (1), (2), or (3) agree to exchange information only between themselves (or their clinics). Any disclosure of information extended beyond these parties is considered a breach of confidentiality.

Your signature below indicates that you understand that you have a right to receive a copy of authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have the right to revoke this authorization at any time unless the therapist stated above has taken action in reliance upon it. Additionally, if you decide to revoke this authorization, such revocation must be in writing and received by the above named therapist at 2385 Lawrenceville Hwy, Suite B, Decatur, GA 30033.

Child's Name: _____

Parent's/Legal Guardian Signature: _____ Date: _____

POLICIES FOR CLIENTS

1. Village Pathways Comprehensive Therapy will bill Medicaid, Care Management Organizations (CMOs), or private insurance. Cash and checks are accepted for payment.

2. A parent/guardian or responsible adult (age 18 or older) must accompany a child to the clinic for the child's appointment. While the child is being seen for the appointment, the parent or responsible adult must stay in the building. If a parent/guardian or responsible adult must leave the clinic area, the therapist or office manager must be notified. This policy has been developed to insure the safety of all children seen for services in the clinic. Failure to abide by the policy may result in discontinuation of therapy services. Children or siblings of the clients (age 17 or younger) also must be accompanied by a responsible adult while in the waiting room or clinic area.

3. For clients who are aided by caregivers, it is necessary for the caregiver to escort the client to the clinic and to remain in the building during the appointment. If the caregiver must leave the clinic area, the therapist or office manager must be notified.

Initials: _____

BILL OF RIGHTS

Clients as consumers receiving physical/ occupational/ speech-language therapy services have:

1. The Right to be treated with dignity and respect;
2. The Right to have services provided without regard to race or ethnicity, gender, age, religion, national origin, sexual orientation, or disability;
3. The Right to know the name and professional qualifications of the person or persons providing services;
4. The Right to personal privacy and confidentiality of information to the extent permitted by law;
5. The Right to know in advance the fees FOR SERVICES;
6. The Right to receive clear explanation of evaluations results, to be informed of potential or lack of potential for improvement, and to express their choices of goals and methods of service delivery;
7. The Right to accept or reject services;
8. The Right to have services provided in a timely and competent manner, which includes referral to other appropriate professionals when necessary;
9. The Right to present concerns about services and to be informed of procedures for seeking their resolution;
10. The Right to accept or reject participation in teaching, research, or promotional activities;
11. The Right to review information contained in their records, to receive an explanation of record entries upon request, and to request correction of inaccurate records;
12. The Right to receive notice regarding reasons for discontinuation of services, an explanation of these reasons (in person, upon request), and referral to the other providers if so requested.

These rights belong to the person or persons needing services. For sound legal or medical reasons, a family member, guardian, or legal representative may exercise these rights on the person's behalf.

Initials: _____

MODEL RELEASE: PERMISSION TO USE PICTURES/VIDEOS

I hereby give **Village Pathways Comprehensive Therapy, LLC** the absolute right and permission to publish, copyright and use pictures of the undersigned in which they may be included in whole or in part, composite or retouched in character or form, which may include print, web and other visual media.

As such, I relieve and hereby agree to hold **Village Pathways Comprehensive Therapy, LLC** free and harmless from any and all liability arising out of the use and/or release of information; interview; photograph/videotape/film; and subsequent publication or broadcast. I understand that the interview(s) or photo session(s) are being carried out upon my consent and authorization and so assume full responsibility.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. I understand that I may see and obtain a copy of the information described on this form, if I ask for it.
5. I get a copy of this form after I sign it.

Images to be used only for **Village Pathways Comprehensive Therapy, LLC** promotional materials and will not be sold.

If the person photographed/filmed is under 18, I certify that I am his or her parent or legal guardian and I give my consent without reservation to the foregoing on his or her behalf.

Name (print):_____ Name (signature):_____

Name (child):_____ Date: _____

Address: _____

City: _____ State: _____

Phone: _____

Email: _____

APPOINTMENT REMINDERS

I, _____ (Print Name), hereby authorize "Village Pathways Comprehensive Therapy" to send me an appointment reminder via e-mail or text message using the following information.

Email reminders may contain patient or clinic information such as,

but not limited to, patient first name and clinic location.

Patient / Guardian Contact Information:
(Please print clearly and legibly)

Email: _____

Cell phone: _____

Patient/ Guardian (Print): _____

Signature: _____

Date: _____