THERAPY AGREEMENT ATTENDANCE AND FINANCIAL POLICY

Hello and thank you for choosing FOCUS to support the developmental needs of your child. As a family-centered agency we appreciate the opportunity to partner with you in supporting your child. We believe parents are the best teachers and as such, we consider and value the relationship we have with children and their families. Please take a moment and become familiar with our attendance and financial policy. If you have any questions please do not hesitate to ask.

ATTENDANCE

Your child's sessions are standing appointments. Consistent attendance is critical to achieve improvement. We require an attendance rate of 80%. We will track visits and notify you when attendance drops below this requirement. We are glad to work with you if scheduling problems arise so please let us know if you are experiencing difficulties with your current therapy schedule.

If you are planning to be out of town for more than 3 weeks, we are unable to hold a therapy spot for you. Kindly let our front desk know of any vacation plans or long term absences.

Cancellations: Consistent with our family centered mission, we strive to be reasonably flexible to schedule changes and conflicts. We request that you inform us of cancellations no later than 24 hours prior to a scheduled session. We understand that illness can have a sudden onset and therefore we allow one last minute cancellation per quarter. Any client cancellations of less than 24 hours will apply to the required attendance rate of 80%. Three consecutive no-shows or attendance below 80% will result of removal of your child from the therapy schedule.

If you need to discontinue services, please provide us with written notice two weeks in advance so that our therapists can finalize treatment plans and complete any necessary documentation.

School Closure Days and hazardous road conditions: If the Anchorage School District closes schools due to weather, you can make a decision as to whether or not to keep your therapy appointment. If you chose to cancel your appointment due to weather, this cancellation will not apply to the allotted number of cancellations per quarter. If you would like to attend your therapy appointment, please call the office and confirm that your therapist has arrived before leaving your home. You can also email your child's therapist and these email addresses can be found on the FOCUS website: www.focusoutreach.org
FINANCIAL

Insurance: As a courtesy to our clients, we will bill your insurance carrier. Not all services are a covered benefit in all contracts and some insurance carriers have an approved number of sessions or exclusionary clauses. Ultimately, it is the family's responsibility to obtain information from their insurance carrier regarding the number of therapy appointments covered, issues with deductible, or co-insurance amounts. We will collect co-pays at the time of service and we accept cash, check, and credit cards. If you use Medicaid, there is no co-pay requirement. Please make your co-pay at the front desk at the time of your child's therapy visit. We will not bill co-insurance until the insurance company has paid for the service. Should you have any billing questions or require special consideration regarding your co-pays, please contact our chief finance officer, Keith Greene, 694-6002.

Because therapy appointments are a weekly, charges can add up quickly. Some insurance companies take 3 or more months to pay on claims and this can leave families with a large balance. Accurate information on covered services is only available once a claim has been made. We have experienced some private insurance companies reporting that therapy services will be covered and then claims being denied. Within a private insurance company, there are many different policies based on the package purchased by your employer. It is not possible for FOCUS to determine the coverage your plan will provide for therapies. Often the answer lies within the fine print or exclusionary clauses that are not written in your summary of benefits packet. Your insurance is a contract between you, your employer, and the insurance company. As such, we are not a party to that contract and only bill as a courtesy to our families.

Below are standard rates for therapy services:

- 30 or 45-minute Speech Therapy session: $168.00
- Speech Therapy evaluation: $408.00
- Occupational Therapy evaluation: $176.00
- 1 hour Occupational Therapy session: $284.00
- 45-minute Occupational Therapy session: $213.00
- Speech Therapy group session: $49.00

Change of Information: It is your responsibility to notify us of any change in address or insurance coverage within 30 days. If we are no longer able to bill your insurance, your balance will be your responsibility.
Child's Name: ___________________________________________
Child's DOB: ___________________________________________

Please detach and turn in after initialing and signing

Please read carefully and initial:

1. _____ I hereby understand the above Therapy Agreement Attendance and Financial Policy and agree to abide by it.

2. _____ 3 consecutive no-shows will result in your child being removed from the therapy schedule. All applicable fees will be assessed.

3. _____ An attendance rate of at least 80% is required for therapy effectiveness. If your attendance falls below 80%, the parent or guardian will be required to meet with FOCUS administration regarding continued therapy services.

4. _____ If you plan to discontinue services, two weeks written notice is required.

5. _____ Your insurance is a contract between you, your employer and your insurance company. We are not a party to this contract and any unpaid fees are client responsibility. As determined in my meeting with the FOCUS billing representative, when my balance reaches $___________ I understand there will be a break in services until full payment is made in full.

6. _____ Our office requires notification of any change in insurance coverage within 30 days of the effective date.

7. _____ Co-pays will be collected at time of service.

8. _____ Co-insurance will be collected via statement once an insurance carrier has paid on a claim.

9. _____ I understand that if there is an absence of greater than three weeks (including vacations and insurance issues) my child will be removed from the schedule and placed on the waiting list.

Parent/Guardian Signature _______________________________ Date __________

FOCUS Rep. Signature _______________________________ Date __________
Client Case History Form

*The following information is for professional use and will be handled confidentially.*

*This information will assist the therapists in completing your child's evaluation.*

**General Information**

Child’s name: __________________________ DOB: ______________________ Age: ______________

Name of person completing this form: __________________________

Relationship to the child: ______________________ Date Completed: __________________

Other Parent/Caregiver’s names and relationship: __________________________

How were you referred to FOCUS, Inc.? __________________________

Male______ Female______ Any Siblings? Y/N names & ages: __________________________

Languages spoken in the home: __________________________

School or Programs attended: __________________________ Grade: __________________

Please list any other therapies your child is attending: (Speech, OT, PT, ABA, etc.)

__________________________________________________________________________

Is your child seen for home-based Infant Learning Services (ILS)? Y/N

*** If you have private insurance, please contact your company and let us know how many sessions are allowable for the following: Speech ________ OT ________ We will always make recommendations based on best practice and need.

**Developmental/Medical History**

Prenatal and Birth History:

Length of pregnancy: ______ Delivery Complications: Y/N Birth Weight: ______________

Please explain if there were complications:

__________________________________________________________________________

Does your child have any motoric difficulties or experience them at a younger age? (head support, grasping, sitting, crawling, walking, eating, feeding, dressing self):

__________________________________________________________________________
Concerns about coordination? Y/N Right handed/ left handed/ ambidextrous

Does your child have any of the following conditions?

- Allergies Yes__ Explain ________________________________
- Asthma Yes__ Explain ________________________________
- High Fevers Yes_ Explain _______________________________
- Seizures Yes__ Explain ________________________________
- Meningitis Yes__ Explain ______________________________
- Brain Injury Yes__ Explain _____________________________
- Drug/Alcohol Yes__ Explain ____________________________
- Muscular Disease Yes_ Explain __________________________
- Vision Problems Yes__ Explain __________________________
- Ear Infections Yes__ Explain ____________________________
- Hearing Loss Yes __ Explain ____________________________ Hearing Tested?____________________
- Attention Deficit Yes_ Explain __________________________
- Autism Yes__ Explain ________________________________
- Stuttering Yes___ Explain ______________________________
- Other Yes__ Explain ________________________________

Current Medications: ___________________________________________________________________

Surgeries/ Medical treatments: ___________________________________________________________________

Previous educational, speech, occupational therapy testing? Y/N Where? __________________________

If you have copies of these evaluations and services, please bring them to the evaluations.
Speech & Language History:

When did your child first do the following?

_______ single words                        _______ speak in phrases                        ______ sentences

How does your child let you know their wants and needs? (looking, pointing, gestures, crying, grunting, physically taking you, single words, phrases, complete sentences)

____________________________________________________________________________________
_____________________________________________________________________________________

Is your child understood by you?  Y/N     Other family members?  Y/N       Others: Y/N

Does your child have difficulty saying certain sounds?  Y/N Examples: __________________________

Does your child respond to his/her name? Y/N                  Does your child name items or pictures?  Y/N

Will your child point to pictures? Y/N                  Does your child ask questions?  Y/ N

Does your child repeat questions or parts of questions rather than answer them?  Y/N

Does your child recite or repeat words, songs, etc. from movies, TV, etc. excessively?  Y /N

Play Preferences:

Who does your child play with? _____________________________

____________________________________________________________________________________

Describe how and with what your child plays? ___________________________

____________________________________________________________________________________

Can your child stay focused on a game or activity similar to their peers or siblings?  Y/N

Does your child use toys and objects appropriately for their age? Y/N Explain:

____________________________________________________________________________________

Is your child interested in other children? Y/N Explain:

____________________________________________________________________________________

Does your child take part in make believe play or role playing? Y/N Explain:

____________________________________________________________________________________
Behavior:

Circle any of the following areas you have concerns about with your child:

- Difficult to manage
- Overly active
- Attention
- Sensitive to noise
- Aggression
- Withdrawn
- Transitions poorly
- Fears
- Fearless
- Sleep issues
- Bed Wetting
- Eating
- Depression

Others: ______________________________________________________________________________

Parent or Caregiver's Statement of the Problem: ____________________________________________
_____________________________________________________________________________________

What concerns you most about your child? _________________________________________________
_____________________________________________________________________________________

What do you hope to gain from this evaluation or treatment? _________________________________
_____________________________________________________________________________________

What particular skills would you like your child to achieve in the next 6 months? ______________
_____________________________________________________________________________________

Is there anything else you would like to add? ______________________________________________
_____________________________________________________________________________________

Thank you for completing this form. The information provided will be beneficial in evaluating your child as well as to make recommendations that assist in meeting the needs of your child and your family.

Please contact us with any questions at (907) 694-6002.