Practices & Policies

Insurance Policy Holders

(As of February 1, 2019)

NOTE: Insurance policy holders are responsible for informing Little Hands of any change in coverage. Failure to do so will result in full charge for treatments.

I. ATTENDANCE POLICIES FOR EXCUSED ABSENCES

- We require 24-hour notification for cancellation due to illness.
- Two-week notification is required for any non-illness absence.
- A charge of $50 will occur for any late cancellations and/or failure to attend scheduled session.

II. VIOLATION OF ATTENDANCE POLICIES

- If a child has 2 or more excused absences within a one-month period, your child may lose their scheduled appointment time.
- If your child has ONE unexcused absence, they may lose their scheduled appointment time.
- If a caregiver is 10 or more minutes late for pick-up, your child may lose their scheduled appointment time.

III. TERMINATION OF THERAPY

If you terminate therapy, for any reason, we require **at least 2 weeks of sessions' prior written notice** in order for the therapist to transition the child out of therapy and complete closure. We reserve the right to terminate our relationship with a client at any time for any reason. Unless circumstances require otherwise, if we terminate the relationship, we will provide at least 2 sessions' prior notice.

IV. PAYMENT

Payments are billed at the beginning of each month for upcoming sessions. A credit card is kept on file and only used for late payments or any unpaid dues.

V. PERSONAL INFORMATION

Insurance Information

Insurance Provider: _____

Medical Record #: _____

Membership Type: ☐ Medi-Cal ☐ Commercial

Co-pay per OT or Speech Visit: $ _____

Service Coordinator: _____

Child's Information

Child's Full Name

Child's Date of Birth (mm/dd/year)

Child's Current Grade

Name of Child's Current School

Current Therapy Services & History of Therapy (if applicable):

Food Allergies (if applicable):

Medications (if applicable):

Contact Information

Contact 1 (Full Name):

Contact 1 (Email Address):

Contact 1 (Phone):

Contact 2 (Full Name):

Contact 2 (Email Address):

Contact 2 (Phone):

VI. CHANGE IN POLICIES & AUTHORIZATION

The terms and conditions in this policy may change from time to time. Such changes will occur with 30 days written notice.

☐ **Authorization:** I agree to the above policies/practices for my child.

Child's Name:

Your Full Name:

Date:

VII. AUTHORIZATION FOR CREDIT CARD USE

(All information will remain confidential)

Billing Information

Name on Card

Billing Address

Billing City

Billing State

Billing Zip

Credit Card Type

☐ Visa ☐ Mastercard ☐ Discover ☐ AmEx

Credit Card Number

Expiration Date

Identification Number

Authorization

☐ I authorize Little Hands Occupational Therapy, Inc. to charge this credit card for late payments on invoices due and payments which have not been paid in due time according to the practices and policies.

Date:

Availability: (Please specify days/times that your child is available for weekly therapy.)