Momentum Therapy Center

Thank you for your interest in Momentum Therapy Center. This packet contains the forms to be completed and returned by email, mail or fax prior to scheduling your first appointment. Physician's order is required from all clients. If you have additional information, such as school or therapy reports, please include them with the new patient forms. If you have questions about the completion of these forms, please call 281-829-0103.

Best,

Momentum Therapy Center

Cristina Gill, M.S. CCC-SLP

Isabel Pelaez, M.S. CCC-SLP

Attendance and Cancellation Policy

In effort to ensure the most efficient and effective outcome for all our patients, Momentum Therapy Center, PLLC. implements the following attendance policy:

If you need to cancel or change your appointment, please notify our office at least 24 hours in advance by calling **(281) 829-0103**. We will do our best to reschedule your appointment.

CANCELLATIONS

1. Momentum Therapy Center, PLLC. Has a 24-hour cancellation policy, with regard to patient consultation, evaluation and/or treatment session. Please contact us as soon as possible if it is necessary to cancel or re-schedule your child's session. We are happy to reschedule your child's session whenever possible. There is no charge for cancelling or rescheduling your child's session when adequate (24 hours) notice is provided, as long as you maintain a 85% attendance rate.

2. Without proper notification, a missed appointment will result in a "no show" charge of $50. This fee is not covered by, nor is it submitted to your insurance company, but rather, billed directly to you.

3. If the clinician needs to cancel your session due to illness or emergency, we will notify you as soon as possible. If a cancellation is necessary for any reason other than illness (e.g., conference, vacation, etc.), you will be notified in advance and we will make our best efforts to reschedule your appointment.

LATE ARRIVALS

1. If you are late to an appointment, the session will need to conclude at the initial time to allow the clinician to stay on schedule. If the clinician is running late for any reason, you will be given the full session time. Our staff regrets any inconvenience to your personal schedule and will make our best efforts to maintain timelines.

ILLNESS

1. In order to keep everyone including therapists, other children/clients, and family members well, please keep child at home for 24 hours after the last occurrence of vomiting, diarrhea, or fever (without medicine).

TERMINATION OF THERAPY

1. The following reasons may be cause to terminate our service agreement:
    a. Non-compliance with our attendance policy.
    b. Engaging in behavior that breaches trust and ethical integrity of the center such as: withholding pertinent information about the case history or requesting therapists to alter data or diagnosis.

2. If you need to terminate therapy for any reason, we ask that you give us written notice a minimum of two (2) sessions in advance. This will allow us adequate time to plan a final consultation with you.

_____ _____

Child's Name Date

_____ _____

Parent's Name Parent's Signature

FINANCIAL POLICY

Momentum Therapy Center, PLLC. has the responsibility to provide quality healthcare services to patients. In the interest of maintaining a good relationship and continuing the delivery of quality healthcare, it is our hope that you will take responsibility for your financial obligation to our practice. Following are general policies we have established for our patients, which we believe allow the flexibility that some patients need. We encourage you to discuss your account and any payment arrangements that you desire with our office personnel. Discussion of these arrangements early on in your treatment process will prevent most concerns or misunderstandings.

1. **Insurance** – As a courtesy to our patients, we will file claims on all visits. When we file a claim on your behalf, it is with the understanding that benefits will be assigned to Momentum Therapy Center, PLLC. (that is, the insurance company will pay Momentum Therapy Center directly). You are responsible for payment of all deductibles, co-pays, co-insurance and non-covered services. Please remember insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for understanding your insurance benefits and for payment to your doctor or provider rests with you.

2. **Referrals** – You are required to; 1) know whether or not your insurance requires a referral, and 2) obtain that referral before you are scheduled to see our therapist. Our office will be happy to assist you in determining the status of our office on your plan. However, this is not a guarantee of coverage. You should take the time to call your insurance company to ask specifically about our office and the covered benefits. Referrals typically have an expiration date and a limited number of visits, so you should be careful to monitor the dates and visits.

3. **No Insurance/Private Pay** – Patients who do not have insurance or choose to pay privately are expected to pay for all services rendered. We will request a payment at the time services are rendered.

4. **Past Due Accounts** – Patients with an outstanding balance over 60 days after insurance payments, who have not responded to attempts for collection, and who have not made arrangements for meeting their financial obligation to us, may have services placed on hold until the balance is paid. Patients with an outstanding balance over 90 days old, under the same circumstances listed above may have their account turned over to a collection agency after being notified by certified mail. Patients who have allowed their account to be turned to an agency will be expected to satisfy their financial obligation to us, and to pay for any future services in advance before being seen by our therapists. Any account balance left unpaid by the end of the month will be charged a 1.5% interest charge.

Credit Card/Debit Card Transaction Processing Authorization Form

_____ **YES,** I would like you to automatically charge my credit card for services rendered each month.

_____**YES,** I would like to have my checking account debited for services rendered each month.

_____ **NO,** I would like to pay in person before every session.

Credit Type (circle one): Visa Master Card Discover American Express

Other: _____

Card Number: _____

Expiration Date: _____

CVV/CVC Code: _____

Name on Card: _____

Billing Address: _____

By signing this Agreement, and marking the box noted above, the undersigned does hereby agree that Momentum Therapy Center, PLLC has the right to charge to the above identified credit card and/or debit the account identified above any and all amounts that are owed. The undersigned agrees that its signature on this Agreement shall be deemed its signature on any sales charge receipt.

Date: _____

Print Name: _____

Cardholder's Signature: _____

Insurance Information

Company: _____

Phone: _____

Address: _____

Member ID#: _____ Group #: _____

Effective Date: _____

Insured's name: _____

DOB: ____/_____/_____ Soc. Sec. #: _____

Relationship to Patient: _____

Employer: _____

Type of Plan: _____

Is there a secondary insurance company? ☐ Yes ☐ No

Secondary Company: _____

Phone: _____

Address: _____

Member ID#: _____ Group #: _____

Effective Date: _____

Insured's name: _____

DOB: ____/_____/_____ Soc. Sec. #: _____

Relationship to Patient: _____

Employer: _____

Type of Plan: _____

NOTICE TO PATIENTS, INSURED AND GUARANTORS HEALTH PLAN DENIALS

Your health plan will pay us only if the services you receive are covered under the terms and conditions of your plan. If you are a member of a preferred provider organization (PPO), health maintenance organization (HMO), or other managed care plan, your health plan may reduce or deny your benefits if:

- the services are not medically necessary
- the services are not approved, ordered or performed by a health plan provider
- the service is not a covered service

Health plans review claims to determine whether the services are medically necessary. Generally, "medically necessary" means services that are:

- appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition
- within standards of medical practice

Momentum Therapy Center, PLLC. cannot accept the financial risk for services, requested by you or ordered by your physician, that are subsequently determined to be not medically necessary. Your financial agreement with us is to pay for all services you receive, whether or not your health plan determines the services to be eligible for coverage.

The undersigned agrees that he/she has read the notice, accepts its terms, and received a copy thereof if desired, and is the patient, the patient's agent, parent, insured or guarantor.

_____ _____

Parent Signature/Guarantor Date

_____

Print Name

Acknowledgement and Assumption of Risk

Date: _____

I, _____ (print name) acknowledge and agree to have my child, _____ (print child's name) receive speech therapy services from employees or independent contractors of Momentum Therapy Center, PLLC.

I acknowledge that there is some risk inherent in the use of the therapy equipment and I agree to assume such risk and indemnify and hold Momentum Therapy Center, PLLC. harmless from any and all losses and claims for any injuries or other damages occurring to myself, my child or our belongings.

_____

Signature

_____

Print Name

Consent to Release Form

I, _____ (print name) give my permission and consent to Momentum Therapy Center, PLLC and respective contractors and employees to discuss and speak with school officials, teachers, psychiatrists, medical doctors, therapists, insurance representatives, and other professionals regarding my child as such may be needed in connection with the treatment and/or evaluation of such child.

In addition, Momentum Therapy Center, PLLC is authorized to receive any records, files, charts, and other documentation and information from such Third Party Professionals, and by signing this document, the undersigned is authorizing the release of any such information that may be held by a Third Party Professional to the Company. Any person who is provided a copy of this document may rely on it as the undersigned's full and unconditional consent to the release of any and all information pertaining to the child. The undersigned further authorized Momentum Therapy Center, PLLC to release any and all information pertaining to the treatment and/or evaluation of the child to any Third Party Professional that may in any way be involved in the treatment and/or evaluation of the child.

The undersigned understands that some or all of the information obtained and/or released under this document may be protected under federal regulations including but not limited to HIPAA. By authorizing a release of information, the undersigned understands and agrees that they are agreeing to the release of such information notwithstanding the protections under HIPPA, provided, however, it is understood and agreed that Momentum Therapy Center, PLLC will maintain the confidentiality of any information obtained and will not disclose the same except as needed in the course of treating or evaluating the child.

_____ _____

Child's Name Date

_____ _____

Parent's Name Parent's Signature

Momentum Therapy Center

Authorization to Photograph and Videotape

I/We _____ (print name) give consent to photograph or videotape of therapy sessions with _____ (print child's name). I understand that visual media can be an important learning and assessment tools and that the use of these media is an integral part of therapy and continued learning. I hereby give my full consent for my child to be photographed, videotaped, and otherwise recorded on media during his/her speech session with Momentum Therapy Center, PLLC.

Please check the box below to acknowledge your agreement on the Photography and Videotaping Policy:

☐ Authorization to Use Photograph and Recordings: I understand that Momentum Therapy Center may use photos and videotapes as training and/or research tools. The use of videotapes for training may include any of the following:

- The viewing of videotapes during clinical supervision.
- The viewing of videotapes with family members for training purposes.
- The viewing of videotapes for training purposes with other professionals.
- The viewing of videotapes during presentations when educating other.

I understand that the use of videotapes is an integral part of the clinical process. I further understand that no photograph or videotape will be released to the public or media without my express written consent.

_____ _____

Child's Name Date

_____ _____

Parent's Name Parent's Signature

General Acknowledgement of Forms

Consent to Treat and Release Records

As the patient or patient's legal representative, I understand that my signature on this consent form gives my consent for treatment by Momentum Therapy Center, PLLC.

Further, I acknowledge that a copy of my insurance card, if applicable, is on file with Momentum Therapy Center, PLLC. They may share and disclose private health information to my referring physician and my insurance company.

Financial Responsibility

I understand that insurance payment of speech and language therapy services is not guaranteed by Momentum Therapy Center, PLLC. Every effort will be made to collect payment for services rendered at this clinic, but if the charges are denied wither in full or in part, the patient/guarantor must pay the full account balance. In addition, I understand I am responsible for all co-payments, coinsurance fees, and deductibles. My signature on this for acknowledges that I have reviewed, understand and agree to the Financial Policy and financial responsibility.

Assignment of Benefits

I authorize payment of any and all benefits from my insurance directly to Momentum Therapy Center, PLLC.

Information Practices and Privacy Statement

My signature on this form acknowledges that I have reviewed, understand and agree to the privacy policy practices of Momentum Therapy Center, PLLC. The Information Practices and Privacy Statement is posted in the office waiting room and copies are available upon request.

_____ _____

Parent Signature/Guarantor Date

_____

Print name

_____ _____

Momentum Therapy Center, PLLC Date

_____

Print Name