Thrive Therapy Associates, LLC

Patient Name: _____
DOB: _____

Conditions of Treatment

This Agreement contains the conditions of treatment of patients at Thrive Therapy Associates, LLC, Lewis Center, OH. The patient or the legal representative is asked to read and sign this Agreement so that the therapists treating patients may provide health care to their patients in an atmosphere where patients and their families/representatives clearly understand their rights and obligations. Please ask any questions before signing this Agreement, a legally binding contract with Thrive Therapy Associates, LLC.

1. CONSENT TO MEDICAL AID. The undersigned consents to the treatment which may be performed during visits including but not limited to speech therapy.

2. TEACHING PROGRAMS. Thrive Therapy Associates, LLC is involved in providing education and training for students in health professions, including but not limited to speech therapy students and other post-graduate students. The undersigned agrees that these trainees may participate in the patient's care under the supervision of the attending licensed practitioner.

3. SCIENTIFIC EDUCATION & RESEARCH. The undersigned consents to and authorizes the taking of pictures of the therapy process, for scientific, educational, or research purposes. Please note below the signature if this is not agreed to.

4. PERSONAL VALUABLES. It is recommended that valuables not be brought to therapy sessions. Thrive Therapy Associates, LLC is not responsible for the loss of or damage to any property or valuables brought to therapy sessions by a patient or by a patient's visitor.

5. FINANCIAL AGREEMENT. The undersigned agrees to the payment procedure outlined. Payment for service is required at each treatment session unless another arrangement has been made i.e. payment for a month in advance. Patient will receive a billing statement to submit to their insurance company if Thrive Therapy Associates, LLC is not a contracted provider for the patient’s insurance company. It is understood by the undersigned that he/she is financially responsible for payment of services.

6. ASSIGNMENT OF HEALTH INSURANCE BENEFITS. The undersigned authorizes direct payment to Thrive Therapy Associates, LLC of any health benefits otherwise payable to or on behalf of the undersigned for his or her outpatient services. Should direct payment of health benefits not cover all charges, it is understood by the undersigned that he/she is financially responsible for any remaining balance.

7. LATE PAYMENT CHARGE. Thrive Therapy Associates, LLC may assess a late payment charge of one percent per month (12.68% APR) on the unpaid balance of any account from the sixtieth day after the account becomes due and payable. In the event the account for services rendered to the patient is referred to a collection agency or an attorney for collection, the undersigned shall pay reasonable collection costs, including and without limitation to, attorneys' fees and court costs, including costs on appeal. The undersigned agrees that if a patient payment results in a credit balance, the money may be applied to any other account which the patient or immediate family owes to Thrive Therapy Associates, LLC.

8. ATTENDANCE POLICY. Thrive Therapy Associates, LLC is committed to supporting the progress and success of our patients and their families. In order for us to see progression it is imperative that treatment is consistent. It is our policy that children attend 80% of scheduled appointments (8 out of 10 scheduled sessions). If you are not able to attend appointments your child may be removed from the schedule.

9. SESSION LENGTH. Thrive Therapy Associates, LLC requests that you be as punctual as possible for the start and stop times of your child’s session. Treatment sessions are 50 minutes for an hour session, 40 minutes for a 45 minute session and 25 minutes for a 30 minute session. The remaining time is used for parent education and documentation.

Conditions of Treatment (Continued)

10. CANCELLATIONS. Thrive Therapy Associates, LLC requires 24 hours' notice for cancellations; otherwise, the patient will be billed for the session. Please contact us if you are not able to keep your scheduled appointment at least 24 hours in advance.
For late cancellations and no shows: You will be billed our Private Pay rates, for the duration of the missed appointment. (1 hour $120, 45 minutes $90, 30 minutes $60)

11. HOLDING OF TREATMENT TIMES. Thrive Therapy Associates, LLC will hold treatment spots for no more than two weeks at no cost to the family. If desired, treatment spots can be held beyond that by paying the private pay rate for those appointment times unless restricted by funding source.

12. **CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION.**

USE/DISCLOSURE OF INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS:

The undersigned understands that as part of healthcare, Thrive Therapy Associates, LLC originates and maintains health records describing health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. This information serves as a basis for planning for and providing care and treatment, a means of communication among the many health professionals who contribute to care, a source of information for applying the patient's diagnosis to the bill, and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

USE OF PATIENT REGISTRATION INFORMATION

Thrive Therapy Associates, LLC will use information collected in the registration process to keep the patient or the patient's legal representative informed of his/her health, research and community services opportunities, the availability of existing and new sites/settings of care/services, and notify the patient or the patient's legal representative of his/her appointments and other health related activities. Please initial on the line if the patient or patient's legal representative OBJECTS TO THE USE of registration information. _____. The undersigned certifies that he/she has read the above, received a copy, and is the patient, the patient's legal representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

DATE:_____TIME:_____

PATIENT / RELATIVE / GUARDIAN / CONSERVATOR (Circle Relationship to Patient)

Printed Name_____

Signature _____

(Rev. 2/21/20)