The **Learning** Fountain, Inc.

...where therapy is fun & children are nurtured to grow & blossom...

Welcome to the Learning Fountain!

Please take a moment to read our clinic protocols - Initial and Sign below

Dear Parents:

You have made an important decision by selecting the Learning Fountain for the therapy needs of your child. We believe that the relationship between patient, family and therapist is paramount in the development and execution of your child's treatment program. Our treatment plans include the family in all aspects of care, so when a patient leaves our clinic, care is carried over at home for maximum benefit. Our Physical, Occupational and Speech therapists are dedicated to providing the best possible programs and services to help your child achieve their maximum potential.

Informed Consent for Occupational & Speech Therapy treatment

Initial_____

1. I am the parent/ legal guardian of (Name)_____. I hereby request and give consent to the staff of the Learning Fountain, Inc. to perform treatment and care for my child as prescribed by a physician and/or recommended by an occupational or speech therapist.
2. I understand and am informed that, as in the practice of medicine, occupational and speech therapy may have some risks. I understand that I have the right to ask about these risks and have any questions answered prior to treatment.
3. I hereby request and give consent to the staff of the Learning Fountain, Inc. to take my child to the restroom as necessary. I understand that toileting is part of activities of daily living and that my child may need help to fully perform the task of clean up, including wiping and hand washing after elimination.

Appointments

Initial_____

4. During the initial visit your child will meet with an evaluating therapist. Once basic parental training is complete, your child will be transferred to another therapist who will continue to follow the established plan of care. This may occur within the second through fourth session of treatment.
5. Therapy sessions will begin promptly. Most therapy sessions are approximately 25 or 50 minutes in duration. Parents/guardians of children under the age of 12 should remain present in the clinic unless otherwise arranged. If you must leave the clinic while your child is being treated we ask that you arrive 15 minutes *prior* to the end of the session to communicate with your child's therapist. NOTE: There is NO supervision for your child before or after therapy. No child will be released from the clinic without a parent or guardian unless other arrangements have been communicated.
6. In accordance with **HIPAA** regulations, you may only enter the clinic when accompanied by clinic personnel. Family members should be in shared treatment rooms/ common areas *only* when accompanying your child or therapist.
7. We understand that sometimes you may not be able to attend therapy without bringing your child's siblings. Other children present during therapy may be a distraction to your child and others, so please use discretion. Siblings must remain with the parent in the treatment room and under parental control. Siblings are NOT allowed in the gross motor room or common areas of the clinic. Although we do have a waiting room we do not advise that you leave siblings unattended. Treatment toys must be available to our therapists and are not available to siblings. Use of equipment by siblings is strictly prohibited.
8. Appointment reminders are sent via email. Please be certain that we have the best email address for this purpose on file. If insurance authorization cannot be obtained in a timely manner, we reserve the right to fill your time slot with another patient.

WARNING - High Risk Patients

Initial_____

9. TLFI treats children with high risk allergies. **DO NOT bring any food items into the clinic that may contain nuts.** If your child has consumed or been in contact with nut related items such as peanut butter or granola bars within the last 4 hours please notify the front desk immediately.

Shared PHI

Initial_____

10. The Learning Fountain communicates with families regarding insurance information and appointments via email.
11. The Learning Fountain will share your child's reports with his/her primary care physician and/or referring doctor or therapist.

You will receive a copy of TLFI's privacy policy and practices for your records.
If you do not want your child's PHI shared in any of the ways stated above, please submit a written statement to TLFI indicating your wishes.

Cancellations

Initial_____

12. To cancel an appointment, please call the clinic at 925.264.9810. In the event no one is available, be sure to leave a phone message with our electronic messaging system. **DO NOT CANCEL VIA EMAIL OR BY RESPONDING TO THE AUTOMATED APPOINTMENT REMINDER.**
    All sick call appointments MUST be cancelled prior to 8:30 am. The only exception is a true emergency such as hospitalization or death in the family.
13. If you cancel more than one time in a 30-day period, your preferred appointment time will no longer be guaranteed. This applies to cancellations for any reason.
14. **When you cancel, you are not adhering to the treatment plan set by your child's therapist.** All cancellations within 24 hours of the appointment time will be subject to a **$35.00 cancellation fee**. If your child fails to attend a regular appointment with no advance notification a **no show/no call fee of $75.00** will be assessed.
15. If you have a vacation or other prior obligations, you have the option of cancelling or rescheduling those appointment times. Patients missing more than two weeks of therapy in one month will be removed from the regular schedule rotation.
16. Our staff practices "standard precautions" to protect themselves and others from illnesses. Please DO NOT bring your child to TLFI if he/she is in the contagious stage or has contracted a communicable disease, such as chicken pox, whooping cough, strep throat, pink eye or head lice. Any child with colored nasal discharge, uncontrolled coughing, diarrhea, vomiting, fever greater than 100 degrees, rash, lethargy or irritability may not attend. **Children must be fever free for a full 24 hours before attending therapy.**
17. You will *not* be given advance notice when a therapist is out sick for the day when *there IS* other coverage available. If a therapist is on vacation other arrangements shall be made for your child to be treated.
    The success of our program requires that your child receive uninterrupted continuity of care. This may mean that on occasion your child will be scheduled with a therapist that they may not have worked with in the past. We consider this a positive experience and an opportunity for your child to learn to trust people other than the therapist/s that they have become accustomed to. For some children this will be an easy transition and for others it may pose a challenge. Please bear in mind that although it can be uncomfortable to see your child struggle with a new therapist, part of the reason that they are here is to break through those boundaries.
    If there is no coverage available for your child on a given day you will be notified directly by the clinic or therapist.

Personal Injury

Initial_____

18. The Learning Fountain, Inc. shall be released from all claims for damages and personal injury, property damage, theft or death which may occur or which may hereafter accrue to patient or their families as a result of participation during therapy or while within the building and surrounding areas. In the event of an accident I agree to seek arbitration on behalf of my minor child and hold The Learning Fountain, Inc. harmless for any damages that may have occurred.

Copayments/Returned Checks

Initial_____

19. Co-pays must be paid at the time of each appointment. All co-insurance, deductibles, non-covered services and out of network balance amounts is the patient responsibility. The Learning Fountain accepts all forms of payment including most major credit cards.
20. Payment will be required at the time service ***if it is determined*** that the insurance company is paying the member or subscriber directly for claims reimbursement. You are required to reimburse the Learning Fountain immediately, upon receipt of funds, from the insurance company for any claims submitted on behalf of your child. As a courtesy, the Learning Fountain will continue to send claims to insurance for processing and payment. In these instances the patient account balance may not exceed $500.
21. Any returned check from a financial institution for non-payment shall result in a $25 fee.

Assignment of Benefits/ Financial Responsibility

Initial_____

22. Any coverage determination, prior authorization, or certification that is made prior to a service being performed is not a promise to pay or pay at any particular rate or amount. Your patient summary plan description typically governs this, as every claim submitted is subject to all plan provisions, including, but not limited to, eligibility requirements, exclusions, limitations, and applicable state mandates.
23. **If TLFI is a provider outside of your insurance network, a lower benefit level may apply; resulting in higher deductibles, co-payments and /or coinsurance. Additionally, utilizing a provider outside of the network may result in significant additional financial responsibility to you. *TLFI may bill you for the difference between our charges and the benefit provided.* Even with a "Network Deficiency Exception"/ "gap exception"/ "ONR"/ "in for out" authorization, the Learning Fountain remains out of network with your insurance at all times.**
24. I hereby assign medical payment to include major medical benefits to which I am entitled, private insurance and any other health plan to The Learning Fountain, Inc. for services provided by The Learning Fountain, Inc. I understand if claims are denied due to eligibility status, invalid medical group, authorization denial, invalid Primary Care Physician, ***or ANY OTHER REASON***, I will assume full financial responsibility.
25. All delinquent accounts over 90 days will be sent to a collection agency at the discretion of The Learning Fountain, Inc. The Learning Fountain reserves the right to discontinue treatment if no satisfactory payment arrangements are made. Please contact our Patient Care Administrators at 925.264.9810 for insurance or billing inquiries between the hours of 9:00 am – 4:00 pm Monday thru Friday.
26. I understand that responsibility for payment for services provided by The Learning Fountain, Inc. for myself or my dependents is my personal responsibility entirely, whether I have healthcare insurance coverage or not. I also understand that if I do have health coverage insurance that it is my personal responsibility to verify coverage and/or benefits regarding any and all services and procedures provided by The Learning Fountain, Inc. I agree that I am responsible to pay 100% of the provider's actual charges without any insurance policy adjustments within (30) days after the date of service. In addition, I agree to pay interest at 1.5% monthly (18% annually), and a one –time delinquency fee equal to 15% of the past due balance. I also agree to pay court costs and attorney fees as may be required to effect collection of any past due balance.

I HAVE READ, UNDERSTAND COMPLETELY, AND AGREE WITH ALL THAT IS WRITTEN ABOVE:

Responsible Party Signature: _____Date:_____

Print name: _____

Name of Patient: _____

Relationship to Patient: _____