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# Financial Statement and Appointment Policy

**Child's Name:**_____

1. We are pleased to offer you the service of billing your insurance company for care you have received from our office. We will fulfill our obligation by completing the necessary forms and providing the necessary documentation pertaining to your claims. It is the responsibility of the parent or guardian to inform us of any and all changes in insurance information. Failure to do so could result in total patient responsibility for charges incurred. The undersigned agrees to promptly pay any co-pays, coinsurance, deductible or non-covered service. The fees we charge for services are usual and customary for this area. My signature below indicates the authorization for payment to be sent directly to Wauwatosa Therapies LLC., for any claim submitted to an insurance or Medicaid on my child's behalf. This includes but is not limited to sessions for which Prior Authorization was requested but denied. For these services and self-pay clients, you will be billed a cash discounted rate of $85.00 per session. I hereby authorize Wauwatosa Therapies to release to any insurance company, physician or hospital all medical information which is necessary to afford proper treatment or obtain payment for services. I hereby assign all payments for services rendered. I have read and fully understand the above and I realize that I am responsible for any charges not covered by my insurance.

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Parent/Guardian **Signature and Initial** Date

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2. It is preferred that you remain on the building grounds for the duration of your child's appointment. As a courtesy, Wauwatosa Therapies will allow parents/guardians to leave the premises during the appointment, however, you must provide Wauwatosa Therapies with a cell phone number to reach you before leaving. If you leave, you must return **5 minutes prior** to the end of the appointment, to ensure that you have arrived **before** the session ends. Wauwatosa Therapies is unable to provide supervision for your child beyond the scheduled 45 minute appointment time. By signing below, you agree to give Wauwatosa Therapies permission to call 911 or Emergency Medical Services in the event of an emergency, while you are not present.

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Parent/Guardian **Initials** Date

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3. It is the responsibility of the patient to notify the front desk of the need to schedule appointments. A master print-out of all future scheduled appointments is available to each patient. Please refer to it regarding the need for future scheduling, beyond what is listed. Appointment days / times are not held indefinitely and should be scheduled based on insurance authorization and medical necessity. Please talk to your treating therapist regarding frequency and duration of sessions, then contact the front desk and schedule accordingly. The frequency and the duration of therapy is at the discretion of the treating therapist, and is based on medical necessity.

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Parent/Guardian **Initials** Date

**Child's Name:**_____

4. If you are unable to make your scheduled appointment, please notify the office as soon as possible, to allow another child to take that spot. If more than 2 appointments are missed without notification via phone, the caregiver / parent will be notified that they have been removed from the schedule.

Parent/Guardian **Initials** Date

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5. Wauwatosa Therapies was created to ensure a therapeutic space for all to enjoy. For that reason, we are unable to accept cases that involve severe physical aggression, active legal litigation, theft, substance abuse and/or sexual concerns. The above stated issues are outside of an Occupational Therapist's scope of practice. We are happy to provide referrals / suggestions for additional professionals that may be able to assist you with your healthcare.

Parent/Guardian **Initials** Date

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6. No siblings are allowed in the treatment rooms / gym. In order to maintain privacy for patients, we ask that family members (beyond a parent or guardian), remain in the waiting room. Siblings that are in the waiting areas must be supervised at all times. For liability and safety reasons, Wauwatosa Therapies staff is unable to supervise children that are not receiving services.

Parent/Guardian **Initials** Date

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7. For infection control and sanitary reasons, socks must be worn in the waiting and treatment areas at all times. When receiving therapy in the treatment areas, you and your child will be asked to remove shoes. Parents, if you don't have socks on, it is okay if you leave your shoes on, just please stay off of the blue mats. If your children forgot socks, socks will be provided.

Parent/Guardian **Initials** Date

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8. If your account would need to be turned over to a collection agency due to non-payment, a fee of 35% of your total bill, will be added to the total amount owed.

Parent/Guardian **Initials** Date