the Center for Pediatric Therapy, inc. 

9 Bristol Court Wyomissing, Pa. 19610

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www.cptherapy.com

Thank you for choosing **the Center for Pediatric Therapy, inc.** (**CPT**) as the therapy service provider for your child. Our staff is committed to providing the highest quality therapy services and experience for our patients and their families.

We apologize for the length and complexity of this Policy, but it is highly important that we comply with the legal terms of our insurance contracts and that we clearly communicate the process, and the rights & responsibilities of both CPT and our patients/parents.

This policy is subject to change. Any changes will be posted in the office and updated on our website. Please request a hard copy if needed. ***Keep a copy of this document for your reference.***

**Your signature is required in three separate (3) places:**

1. **FINANCIAL POLICY**
2. **ATTENDANCE/CANCELLATION POLICY**
3. **HIPAA**

**FINANCIAL POLICY**

**Effective 3/1/2023**

Please understand that payment of your bill is considered a part of your treatment process. As part of our

service to you, we try to contain the ever-rising cost of health care. In our effort to do this, we have implemented this Financial Policy.

Completion of ALL financial intake forms, including a **SIGNED** receipt acknowledging your understanding and agreement with the terms of this policy is required **PRIOR to your first appointment.**

**IT IS YOUR RESPONSIBILITY TO READ AND UNDERSTAND THE CONTENT OF THIS POLICY.**

Please ask if you have any questions.

# **PAYMENT**

We charge what we consider reasonable based on industry standards, the expenditure of our time, resources and expertise. “Payment due” may include any unmet deductible, co-insurance and/or co-pay amount as defined by your health insurance company, private pay for “non-covered” services and any late cancellation/no show fees.

* **CO-PAY** and **PRIVATE PAY** fees are expected at the time of service.
* **CO-INSURANCE** will be billed to you after the claims are processed by your insurance.
* Estimated **DEDUCTIBLE** may be collected at time of service. Any unmet deductible balance will be billed to you after the claims are processed by your insurance.
* **LATE CANCELLATION / NO SHOW** fees are due prior to your next appointment.
* Our **PROMPT PAY** rate is applicable for private pay services ONLY when paid at time of service.

We will accept cash, checks, debit or credit cards including **Visa, MasterCard, Discover** and **American Express. Payments can be made securely via our website for your convenience.**

**EASY PAY**

You have the option to pay by signing up for**EASY PAY.** An ***Easy Pay Consent Form*** is required for this service. The convenience of **EASY PAY** will allow us to bill your debit/credit card for any charges, co-pays or deductibles which are your responsibility but not paid at time of service. Your debit/credit card information will be safely stored in the “electronic vault” provided by our credit card processor.

## **INSURANCE**

***Please remember that insurance is a contract between YOU and YOUR insurance company. Ultimately, you are responsible for understanding your benefits.***

You are financially responsible for costs including deductible, co-payment and/or co-insurance based on your individual plan. Any costs not covered by your insurance are your responsibility. Refer to your ***Explanation of Benefits* (EOB)** for specific information.

Health insurance coverage varies widely. We will assist with verification of your benefits prior to your first appointment. However, this is not a guarantee that your insurance will cover the cost of services rendered. Benefit plans are ever changing and accurate information may be difficult to obtain from your insurance company.

Even though we may participate with your insurance provider, some services may be deemed **“not a covered service”** under your specific insurance plan. You are financially responsible for any services considered “non-covered” by your health insurance company.

CPT is a **“participating provider”** with multiple insurance plans. We will submit all insurance claims for payment for our services with these companies. A list of these participating insurance plans is available on our website or upon request. We accept the contracted amount for services provided.

If your insurance company does not reimburse CPT within a reasonable period of time (90 days), you may be billed. CPT may elect that no “cash pay discounts” will be applied after 30 days of our original service date to you.

**We will not file claims for health insurance plans we do not participate with (“non-participating” or “out-of-network”).** **Payment is due at time of service.** Based on your “out-of-network” benefits, you may be able to file such claims directly with your insurance company. We will provide you with a document which contains information required to file your claim (i.e., diagnosis and treatment codes, units of service, provider information, payment made, etc.).

If you do not have active insurance, if we do not participate with your specific insurance or if for any reason your insurance will not pay for our services, payment in full is expected at the time of your visit regardless of any insurance company’s unique determination of usual and customary rates (UCR).

**CLAIM DENIALS / APPEALS**

If your claim is denied due to a billing error, CPT will make the corrections and submit the claim for reprocessing at no cost to you. If a claim is denied based on your benefits (i.e., “non-covered service”), you will be billed. You have the right and option to appeal the decision made by your insurance company. You are responsible for any charges not paid by your insurance during the appeal process. If your appeal results in the denial decision being over-turned and your insurance company eventually pays the claims, CPT will refund or credit any payments that you made for the disputed therapy services.

**Upon your request, CPT may assist you with the appeal process or file an appeal on your behalf.** **A fee of $20.00\* per 15 minute “unit” will be charged for this service.** This fee is your responsibility and cannot be billed to your insurance company. If the decision is overturned, the cost for assistance with your appeal is not refundable. Although we will make every reasonable effort to support your appeal case, there is no guarantee that the appeal will result in payment of your claims.

**MISSED APPOINTMENTS (No Show & Late Cancellation)**

Cancellations require 24 hour notice. **There is a $40.00 fee\*** **for a NO SHOW or LATE CANCELLATION with less than a 24-hour notice.** Your cancelled appointment may be a valuable appointment opportunity for another patient requiring therapy. Your child’s therapist has also invested time preparing for the appointment. Please help us serve you better by keeping your scheduled appointments or providing advanced notice of cancellation. **In certain circumstances, a $20.00\* REDUCED LATE CANCELLATION FEE may be applicable.** **Refer to the *Cancellation and Attendance***

***Policy* for additional details.**

**ADDITONAL CONSULTATION and/or CORRESPONDENCE**

There may be times when you request **additional** **consultation services** that requires the expertise from our therapists outside of therapy sessions. This is not billable to your insurance company. Examples may include consulting with school personnel regarding your child’s communication (AAC) device or treatment; parent follow-up consultation, attendance at an IEP meeting, school observation/consultation, etc.

Requests for **additional correspondence or documentation** (verbal or written communication) with individuals outside of CPT may include reports or notes in addition our Daily Treatment Notes or Care Plans or completion of forms, letters, copying therapy records, etc.

**A CONSULATION/CORRESPONDENCE FEE of $20.00\* per 15 minute “unit” of time may be charged to fulfill your request.** The charge will be determined by the length and complexity of your request. This fee is your responsibility and cannot be billed to your insurance company.

**DELINQUENT ACCOUNTS**

Payment is due either at time of service and/or upon receipt of an invoice as specified above.

**Accounts NOT paid within 30 days of invoicing or prior to the next billing cycle will be subject to a $25.00\* DELINQUENT ACCOUNT FEE for each additional billing cycle the balance remains unpaid.**

If your account is **not paid in full within 90 days of invoicing** and it becomes necessary to turn your account over to a **COLLECTION AGENCY**, you hereby agree to be responsible for all costs of collection on unpaid balances including, but not limited to, postage fees, 1.5% interest (18% annually), collection fees (up to 50%), court costs and reasonable attorney fees\*.

It is our policy that when an account is **90 DAYS OVERDUE** and/or has been referred to a **COLLECTION AGENCY**, that we **TERMINATE ANY FUTURE THERAPY UNTIL THE ACCOUNT IS SATISFIED**. This limits the amount of debt you may be accumulating.

No “discounts” of any sort will be applied to any outstanding balances or balances sent to collection. If we later receive payment from your insurer, we will refund any overpayments to you.

In certain situations, a **PAYMENT PLAN CONTRACT** may be required in order to fulfill your financial obligation. Failure to adhere to the requirements agreed to in the Contract may result in termination of services and the account may be referred to a collection agency.

**RETURNED CHECK FEE**

There will be a **$35.00\* service charge for CPT to process checks returned for INSUFFICIENT FUNDS**. There will likely be a bank charge as well.

**PERSONAL INFORMATION**

We want to assure you that we take very seriously the responsibility to safeguard any and all of our patient’s medical, personal, insurance and financial information. Therefore, we have established certain policies and procedures to ensure that your personal and financial information will never be shared with anyone outside of this office who is not involved in your therapy or financial processes without your written consent.

With the increasing incidents of identity theft, we realize our patients/parents may be concerned about our need to obtain your social security number, driver’s license number, date of birth, and other personal information. Please do not be offended!

**WHY WE MUST OBTAIN YOUR SOCIAL SECURITY NUMBER –**

In essence, we are granting you **credit** by rendering services to you **before** you, or your insurance company, pays us for those services. Any merchant that grants you credit will require your social security number.

If, after reading the above information, you choose to withhold **ANY** of the information our office requires to establish your medical record and financial account, you will then have two choices:

1. Before services are rendered, we will need for you to complete our ***Easy Pay* *Consent Form*** to

allow us to bill your debit/credit card for any charges, co-pays or deductibles which are your responsibility unless paid at time of service.

 2) You have the option to seek care elsewhere.

**SUMMARY OF FEES:**

***\*These fees are your direct responsibility and will not be billed to your insurance company.***

* **$40.00 NO SHOW FEE**
* **$40.00 LATE (<24 hours) CANCELLATION FEE**
* **$20.00 LATE (<24 hours) CANCELLATION FEE EXCEPTION**
* **$20.00 per 15 minute “unit” CONSULATION / CORRESPONDENCE FEE**
* **$20.00 per 15 minute “unit” INSURANCE APPEAL**
* **$25.00 DELINQUENT ACCOUNT FEE**
* **$35.00 RETURNED CHECK FEE**

***BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND AGREE TO ADHERE TO THE FINANCIAL POLICY*.**

**Parent/Guarantor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CANCELLATION & ATTENDANCE POLICY**

**ILLNESS - WEATHER - ADVANCE NOTICE**

**Effective 3/1/2023**

The Center for Pediatric Therapy (CPT) highly values your time and the time and efforts of our therapists. Therapy appointments, particularly after school, are in high demand and require everyone’s effort to assure efficiency and continuity of services for all children.

**CANCELLATIONS REQUIRE A 24-HOUR NOTICE.**

**There is a $40 fee for a NO SHOW or LATE CANCELLATION**

**with less than a 24-hour notice.**

**CALL (610) 670-8600**

**VOICE MAIL is available 24/7** (Voice mail is date and time stamped)

Your cancelled appointment may be a valuable scheduling opportunity for another child. In addition, your child’s therapist is here and invests time prior to the appointment (i.e. planning and preparing activities for your child’s session).

Some of our therapists work with us part-time and/or manage schedules at other locations. Therefore, a timely cancellation is particularly important as it may impact their scheduled arrival time. We will notify your therapist immediately upon notice of your cancellation so they can adjust their schedule and plan accordingly.

**Cancellations may occur for a variety of reasons including:**

* **Pre-planned** (vacations, known schedule conflicts, etc.)
* **Illness** (sudden onset or on-going over several days)
* **Emergencies** (car accident, death in the family or extreme illness)
* **Inclement weather**
* **Unintentional events** (car trouble or traffic jam on the way to scheduled therapy appointment; schedule delay at another appointment immediately prior to therapy appointment).
* **Work schedule changes**
* **Forgot appointment**
* **Scheduling miscommunication** with whomever is bringing your child to therapy

**ADVANCE NOTICE CANCELLATIONS**

Please notify your therapist or call the office **AS SOON AS YOU ARE AWARE THAT CANCELLATION or RE-SCHEDULING IS NECESSARY** (vacations, holidays, known schedule conflicts, etc.).

Likewise, you will be given advanced notice of your therapist’s planned absence and coverage arrangements for your child’s therapy sessions.

You may be asked to complete an ***Advanced Notice Cancellation Form***during times of higher frequency scheduling changes (holidays, summer). Advanced planning allows us to offer that time to someone else who may need to re-schedule.

**ILLNESS**

Our goal is to keep everyone healthy!!! **Please DO NOT BRING YOUR CHILD if he/she is SICK**.

Please keep contagious illnesses at home. **We require that your child is fever free or has not vomited for 24 hours prior to returning for therapy.** Other potentially contagious illnesses (pink eye, chicken pox, unexplained rash, severe respiratory illness, staph/MRSA, lice, bedbugs or other infestation, etc.) may require a written physician confirmation that your child is cleared to return for therapy.

If your child arrives for therapy and is visibly ill and potentially contagious, **we reserve the right to refuse treatment** in order to protect the wellness of other children and our staff.

Likewise, **we will notify you immediately if your therapist is ill**. Cancellation calls will be made to the **preferred method of contact** (phone, email) that you indicated at the start of services. It is your responsibility to notify the office if your contact information changes. You will be asked to confirm that you received our cancellation message. We do not want you to make an unnecessary trip.

**“SUDDEN ILLNESS”** - We are aware that illness does not always afford us 24 hours’ notice!!!

**PLEASE CALL THE OFFICE IN THE MORNING or AS SOON AS YOU ARE AWARE OF YOUR CHILD’S CONDITION** if your child:

* **wakes up ill during the night or in the morning** **and stays home from school** on the day of his/her scheduled appointment.
* needs **to picked up at school due to illness** on the day of his/her scheduled appointment.
* **comes home from school ill** on the day of his/her scheduled appointment.

**Exceptions to the late cancellation fee policy may be made in such situations.**

**LATE CANCELLATION FEE EXCEPTION (reduced cancellation fee):**

In the event of a “SUDDEN ILLNESS” or certain “UNINTENTIONAL EVENTS” that does not allow for a 24-hour cancellation notice on the same day of your child’s appointment (see above) a **reduced cancellation fee of $20 may apply**. Please keep in mind that your therapist is here and prepared for your child’s session.

In the event that your child has been ill (on-going / >24 hours) and you do not provide 24-hour notice, **the full $40 late cancellation fee will apply.**

Work schedule changes, forgot appointments and scheduling miscommunication regarding travel arrangements for your child **DO NOT qualify for the LATE CANCELLATION EXCEPTION.**

**WEATHER**

Our office is generally open and **DOES NOT follow school district closings** for inclement weather.

If CPT decides to **CLOSE**, **you will be notified as soon as the decision is made. If you do not hear from us, WE ARE OPEN.** Cancellation calls will be made to your **preferred contact number**. It is your responsibility to notify the office if this number changes. If the weather is questionable, make sure to **check your messages prior to leaving for your appointment…or just call us**!

**If CPT is OPEN, it is ultimately YOUR decision to cancel a scheduled appointment based on your comfort level.**

Please call to cancel in a timely manner to avoid the **LATE CANCELLATION** or **NO-SHOW FEE** and allow us adequate time to contact your therapist before they possibly drive to CPT unnecessarily.

**If CPT is OPEN, weather cancellations may be subject to the lesser LATE CANCELLATION FEE EXCEPTION of $ 20 or the $40 fee will apply for NO SHOW.**

**ATTENDANCE**

**FAMILY COMMITMENT AND CONSISTENCY OF TREATMENT IS VITAL and we take this very seriously. We hope that you equally value the service we provide for your child.**

We make every attempt to schedule appointments on the same day and time each week. It is critical that you arrange an appointment time that you can be sure to accommodate.

Every appointment time that you schedule for your child “reserves” the therapist’s time and treatment space. Please be mindful that your child’s therapist invests time prior to the appointment to plan and prepare activities for your child’s therapy session.

We understand that illness, occasional schedule conflicts and planned vacations will occur. Advanced or timely cancellation is extremely important. Your cancelled appointment may be a valuable scheduling opportunity for another child. Rescheduling your child’s therapy, when possible, allows for continuity of treatment.

Your commitment to bring your child to therapy consistently and on time is critical for progress to occur.

If you arrive late for a scheduled appointment, your child’s session will be cut short and will end at the regularly scheduled time. You will be charged the full fee for the therapy session. If you arrive too late to even begin the session, you may be charged a $40 late cancellation fee.

Attendance, including frequent or “late cancellations” and “no-shows”, is documented in the medical record. Your child’s doctor has prescribed therapy services and has access to the medical record information to review progress. The medical record information is also provided to your insurance company for authorization and payment approvals. Inconsistent attendance may affect your insurance company’s decision to authorize and pay for therapy services.

Therapy is a dynamic and on-going process. The therapist’s role is to identify issues and guide the treatment process by educating and empowering children and their families. Therapy does not last forever! Therefore, your child’s progress and success require a major commitment from you that goes beyond the time a child spends directly with the therapist. Our expectations for active follow through with Home Programs and recommendations are high.

In some cases, a family may need to re-assess their individual circumstances, family dynamics, lifestyle and current priorities. Perhaps therapy may be more beneficial for your child at a future time when it can be made a priority.

**FREQUENT CANCELLATIONS OR MISSED APPOINTMENTS**

Cancellation patterns are monitored. Inconsistent attendance and/or frequent late arrivals may result in the loss of your preferred scheduled appointment time or the termination of service**.** This will allow others who can attend consistently the opportunity to schedule, particularly during the “prime” treatment times (i.e., after school).

**FREQUENT CANCELLATIONS or LATE CANCELLATIONS and/or NO SHOW for scheduled appointments will result in a conversation regarding your ability to commit to your child’s therapy at this time. Three (3) or more LATE CANCELLATIONS (<24 hours) or NO-SHOW appointments in six (6) months may result in termination of services.**

**BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND AGREE TO ADHERE TO *THE CANCELLATION & ATTENDANCE POLICY*.**

**Parent/Guarantor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HIPAA PRIVACY POLICY**

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT**

**Effective 3/1/2023**

This notice describes how **protected health information (PHI)** about your child/you may be used and disclosed and how you can get access to this information. PHI includes demographic information that may identify you and may relate to your child’s past, present or future physical or mental health condition and related health care services. Please review it carefully.

**UNDERSTANDING YOUR OR YOUR CHILD’S HEALTH RECORD / INFORMATION:**

When your child becomes a patient at the Center for Pediatric Therapy, Inc. (CPT), there is basic demographic and historical information that you provide to us that we place it in your child’s file. Each time your child has an appointment with one of our therapists, a record of the visit is made. Typically, this record contains diagnostic, evaluation and treatment information including information you shared with us from other health care providers. It may also contain a plan for future care or treatment. This information is often referred to as a health or medical record and serves as a:

* Basis for planning your child’s care and treatment
* Means of communication among the many health and other professionals who contribute to your child’s care
* Legal document describing the services your child received
* Means by which you or a third party can verify that services billed were actually provided
* A tool in educating health professionals
* A source of data for ongoing care
* A possible source of information for planning and marketing for CPT. NOTE: This mailing list would be for CPT use only and not shared with any other organizations)
* A tool with which we can assess and continually work to improve the care we render and the outcome we achieve

**UNDERSTANDING WHAT IS IN YOUR HEALTH RECORD AND HOW YOUR HEALTH INFORMATION IS USED HELPS YOU TO:**

* Ensure its accuracy
* Better understand who, what, when and why others may access your health information
* Make more informed decisions when authorizing disclosure to others

**YOUR HEALTH INFORMATION RIGHTS:**

Although your child’s/your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

* Request a restriction on certain uses and disclosures of your information
* Obtain a paper copy of the notice of information practices upon request
* Inspect and copy your health record
* Amend your health record
* Obtain an accounting of disclosures of your health record
* Revoke your authorization to use or disclose some or all health information to all or some individuals, except to the extent that it has already been used

**OUR RESPONSIBILITIES:**

The Center for Pediatric Therapy is required to:

* Maintain the privacy of your protected health information (PHI)
* Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you or your child
* Notify you if we are unable to agree to a requested restriction
* Accommodate reasonable requests you may have to communicate PHI

We reserve the right to change our practices and to make new provisions effective for all PHI we maintain, provided that it is legal under the HIPAA laws. Should our information practices change, we will mail a revised notice to the address you’ve supplied us.

We will not use or disclose PHI without your authorization, except as described in this notice.

**EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH PROCEDURES:**

***We will use your PHI for treatment:*** For example, your therapist will record the events of a session and may indicate plans for the next session, which may include communicating with outside providers, school personnel, or other family members. Because we work as a team, we may share information with another therapist who serves your child. This is to maximize the quality of care and provide consistency.

***We will use your PHI for payment:*** For example, a bill may be sent to you or a third-party payer (your health insurance company). Your insurance company may also require medical records to authorize continued services. The information on or accompanying the bill may include information that identifies you, as well as your child’s diagnosis, procedure codes, plan of care and progress.

***We may disclose PHI to our business associates that perform functions on our behalf:***

We may use other companies to perform electronic medical record, billing, information technology (IT) and debt collection services on our behalf. Our business associates, including collection agencies, may disclose necessary PHI to their vendors and business associates including but not limited to, third party mailing companies. All vendors and business associates are obligated to protect privacy of your information.

**PORTABILITY OF THERAPY RECORDS**

In the event that you request any of your child’s medical record information be conveyed to another health care practitioner or educational professional, CPT will handle the situation with the utmost confidentiality. A SIGNED ***Consent to Release or Request Confidential Information*** form is necessary for us to release any medical information (written or verbal) to another party. As a courtesy, we will convey a copy of your child’s evaluation report to one (1) provider (doctor, agency, etc.) of your choice. A **fee**\* may be charged for any additional requests for conveyance of health records in accordance with the Pennsylvania ACT #26.

 **BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND AGREE TO ADHERE TO *THE* HIPAA POLICY.**

**Parent/Guarantor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**