Name:
DOB:
Telephone #:

SERVICE AGREEMENT

1. I authorize the performance of the diagnostic tests, procedures and treatments that may be deemed appropriate by the speech-language pathologist and/or occupational therapist. Please see the "Physician Order/Referral" form for the description of services for this client.

2. Anticipated frequency and treatment plan will be determined after the evaluation and described in the initial certification and in the initial evaluation. Continued updates in the treatment plan will be made ever 90 days. Please see the "Speech Evaluation" or "Occupational Therapy Evaluation" form and the "Progress Note" form for the frequency of services for this client.

3. The rate of service for an evaluation is $175 and for treatment is $120. Your third party payer will be billed directly. Any deductible amounts or co-payments are your responsibility. In the event the insurance company or other payer does not pay for services rendered, you will be responsible for paying Kidspeak, Ltd. This assignment to remain in effect until revoked by me in writing.

4. It is the parents'/guardians' responsibility to inform Kidspeak Ltd. of any insurance information changes. Failure to notify Kidspeak Ltd. in advance of any insurance change will result in parents/guardians being responsible for payment of therapy services rendered before notification and/or prior authorization can be obtained.

5. I authorize Kidspeak, Ltd. to disclose all medical information about my child to my insurance company, HMO or other third party payer, as may be necessary for the payment of my bill, determination of my benefits, or for utilization of quality review purposes. I further authorize the release of this information to other health care agencies, professionals or persons, who may provide health care services deemed necessary for continuing medical care.

6. If a therapist is unable to provide service, we will make every effort to reschedule your child or make appropriate referrals.

7. I understand that Kidspeak, Ltd. will not be responsible or liable for loss or damage to any money, jewelry, or other personal property or articles that are worn by the client or are in the client's home.

Kidspeak, ltd.
specialized speech & language and occupational therapy services
6936 garland lane north
maple grove, mn 55311
fax (763) 416-4530 **tel. (763) 416-9313**

8. A parent, guardian or caregiver over the age of 17 must be on the premises at all times during evaluation and treatment sessions.

9. Some Kidspeak Ltd. clinicians have Kidspeak Ltd. stickers or window clings displayed on their vehicles. If you do not want a vehicle parked at your home with the name of our company, please inform your clinician.

10. I received a copy of the MN Home Care Bill of Rights.

11. Circumstances in which emergency medical services (i.e. CPR) are not to be summoned: _____.

12. **No show policy:** It is important that your child receive his/her therapy services as scheduled. We respect your time and we expect ours to be respected as well. Your therapy time is reserved especially for you. Under the No-Show Policy, cancellation notice must be given no less than two hours prior to the appointment. If you fail to notify the Kidspeak Ltd. office or your child's therapist of you intent to cancel at least two hours before the scheduled appointment, you will be charged a fee of $30 per incident. As long as you notify us of your desire to cancel your appointment according to the terms of this policy, you will not be charged this fee.

_____ _____

Signature of client or responsible party Date

_____

Relationship to client

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