Children's Therapy Place
New Client Handbook

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Welcome!

Welcome to Children’s Therapy Place, Inc. (CTP). Our services cover the full spectrum of pediatric therapy to meet all of your family’s needs.

Children's Therapy Place, Inc. provides:

- Speech/Language Therapy
- Occupational Therapy
- Physical Therapy
- Developmental Therapy/Habilitative Support (HS)
- Intensive Behavioral Intervention (IBI)/ Habilitative Intervention (HI)
- Service Coordination
- Mental Health Counseling
- Telepractice Services
- Educational Tutoring

Our programs are designed to meet the individual and varied needs of every child and family. Therapy is offered in both individual and group sessions in a child-friendly atmosphere. Therapy sessions can also be conducted at off-site locations, including homes, childcare centers, and schools. CTP staff work with other community agencies to coordinate services for your child.

This new client handbook contains very important information about our policies, financial obligations, insurance company guidelines and regulations, and advocacy. Please read the contents carefully.

Thank you for choosing Children’s Therapy Place. We look forward to working with you and your family!

Sondra McMindes, M.S. CCC-SLP
Owner

Client Information/Guarantee of Payment

Child's Name ____ Age ______ Date of Birth ___________

****

Mother's Name ______________________________________ Social Security #___________________

Home Address ____

City __________________________ State ___________ Zip Code _______________

Home Phone ___________________ Work Phone ___________________ Cellular Phone ________________

Email ____

Employer's Name ____

Employer's Address ____

****

Father's Name ____ Social Security #_____________________

Home Address ____

City __________________________ State ___________ Zip Code _______________

Home Phone ___________________ Work Phone ___________________ Cellular Phone __________________

Email ____

Employer's Name ____

Employer's Address ____

****

Emergency Contacts (if parent/guardian can't be reached)

Name ____ Phone 1 ____________________________

Relationship ______________________________________ Phone 2 ____________________________

Parent/Guardian Authorization:

I ________________________, Parent/Guardian of ___________________, give permission for my child to receive an evaluation and/or therapy services provided by Children's Therapy Place, Inc. In addition, I agree to pay for services provided by Children's Therapy Place, Inc. Additional services requested that I request (i.e. attendance at IEP meetings, additional file review/documentation, etc.) will be billed at an hourly rate, based on the current fee schedule. Payment for services are due at time of visit, unless other arrangements have been made. There will be a $35 charge on all returned checks. A monthly interest charge of 1.5% is applied to patient balances greater than 30 days.

____ ____________________
Parent/Guardian Signature Date

Appointments, Cancellations, and No-Show Policy

Many of our therapists keep their own appointment schedules; if you have misplaced your therapists contact information, please call the office at: 208-323-8888. Our office hours are Monday – Friday from 8am to 5pm.

Cancellations:
Attendance is a key factor to the therapy process. CTP requires a 24-hour notice for cancellations and/or rescheduled appointments. A $25 charge will be assessed to your account for no-show appointments or cancellation with less than a 24-hour notice. This fee is due prior to your next appointment. *If you need to cancel an appointment or reschedule, please contact your therapist or call the office.*

If your child is not feeling well and you are not sure whether to cancel therapy or not, below are some helpful guidelines to aid you in deciding whether or not to cancel therapy: If your child is/has:

Coughing
Sneezing
Vomiting
Running a fever
Runny nose with green or yellow discharge
Undiagnosed skin rash
Pink Eye

Please call the therapist 24 hours in advance of your appointment, if possible via their cell phone or the office phone, to cancel your appointment.

By keeping your sick child resting at home you will speed up the recovery time and get them back on track sooner. Your therapist also would appreciate not being exposed to illnesses.

Please help us in keeping all of our children and our staff members healthy!

Deciding to pursue therapy for your child is a very important step in enhancing your child's development. It is a serious commitment that is entered into by you and the therapist that is providing services for your child.

When you schedule an appointment, that appointment becomes your child's reserved time. Once that appointment is made, you must commit to being there, the same way the therapist is committed to being there. It is a shared commitment which will work only if both parties take it very seriously. Our goal is for your child to attend at least 90% of the scheduled appointments. Please discuss the frequency of your child's appointments with your therapist if you are unable to maintain this expectation.

There are times when missing an appointment is unavoidable. We would prefer 48 hours notice, but will graciously accept 24 hours notice of cancellation. However, anything less than 24 hours is a breach of the mutual commitment between you and your therapist. Simply not showing up at all is unacceptable. If you do not notify us at least 24 hours prior to the scheduled time, we reserve the right to charge a fee of $25.00 for lack of notification. This fee will be automatically charged to your child's account and payment is expected prior to the next scheduled therapy session. This charge cannot be billed to your insurance company or Medicaid. It is solely your responsibility to pay these charges.

Our therapists are committed to maintaining the highest standards possible for your child's optimum progress. Thank you for your continued business with CTP!

Insurance Information

Financial responsibility helps you maximize your treatment benefits and maintain accountability for the business portion of your treatment process.

You are financially responsible for all services.

- Co-payment, deductibles, and/or percentage are due at the time of service
- For your convenience our office accepts cash, personal checks, Visa, Discover, and Mastercard
- There will be a $35 charge on all returned checks
- A monthly interest charge of 1.5% is applied to patient balances greater than 60 days, and pending insurance claims greater than 60 days

INSURANCE

CTP files insurance and Medicaid claims as a courtesy to you. We provide therapy services as ancillary providers for a number of health insurance companies. As ancillary providers, CTP is not an employee of any insurance company. The insurance company has chosen our agency to provide quality services to you to meet their need to provide therapy services under specific benefit plans.

Your services will not be covered by your insurance company if your specific diagnosis/therapy is not a covered benefit under your chosen health plan. READ AND CONFIRM YOUR BENEFIT PLAN.

WHAT IS INVOLVED IN FILING INSURANCE CLAIMS?

Benefit verification:

Benefit verification is not a guarantee of payment from the insurance company.

CTP staff may verify benefits prior to your initial evaluation or treatment session. Verification tells you whether payment is available for the evaluation under your benefit plan, but it is not a guarantee of insurance payment.

Authorization updates: Insurance companies usually give a specific number of services based on your plan benefits or insurance company regulations. You may or may not be eligible for additional services when your authorization expires and re-authorization will require an authorization update. You will be notified when your authorization expires and how that expiration affects your treatment and payment status. We try to avoid lapses in treatment coverage while updating authorizations. This is not always possible. We accept private payments at any time during your tenure with CTP. We hold therapy time spots for a limited number of sessions and encourage you to actively participate in the authorization process.

Idahoans who experience problems with insurance may contact the consumer affairs office at 334-4250 or www.doi.idaho.gov.

WHO FILES INSURANCE CLAIMS?
CTP files insurance claims for approved services to companies for whom we are providers. We file claims in a timely fashion and expect payment within fifteen days of filing. CTP does not file for reimbursement for services to Medicare members. We can complete any necessary statement requirements if requested by you for filing.

FAILURE OF YOUR INSURANCE COMPANY TO RESPOND TO CLAIMS
If your insurance company fails to respond to a claim within sixty days of our filing date, ***you are responsible for immediate payment*** of all the billed services. interest will begin accruing at 1.5% for balances billed to insurance over 60 days past due.

CO-PAYMENTS
Co-payments are integral to many insurance plans. An administrative staff member will collect your co-payment at the time of service. **By law, co-payments cannot be waived.**

DEDUCTIBLES
Coverage for services is available only after you meet all deductible obligations based on your benefit plan. CTP will charge you the regular insurance rate until you meet those obligations.

CO-INSURANCE
Co-insurance payments are payable to an administrative staff member at the time of each service.

PRIVATE PAY
Private pay agreements are worked out through the CTP billing department as needed.

MEDICAID and KATIE BECKETT BENEFITS
CTP files Medicaid and/or Katie Beckett claims for approved services. We file claims in a timely fashion and expect payment within fifteen days of filing. Medicaid and/or Katie Beckett benefit eligibility is checked on the first of every month by CTP, however, **it is your responsibility to know and maintain the status of your Medicaid and/or Katie Beckett eligibility and to inform CTP of a change in the status or eligibility**.

You are financially responsible for all services.

HOW TO READ YOUR INVOICE/STATEMENT
You will receive monthly invoices or statements during ongoing therapy services and thereafter. You may request an additional invoice or statement at any time from the CTP billing department. The invoice or statement will reflect the status of your account, if your insurance company has made a payment to your account, co-payments, and if any balance is due. If you have questions regarding your invoice or statement please contact the CTP billing department.

Payments and Charges

CTP offers payment options to help you meet the financial obligations associated with the therapy process.

PAYMENT METHODS
Cash payments: Cash and personal checks are accepted
Credit card payments: Credit card payment options are available. Credit card payments can be made onsite at the Boise office location or online via PayPal Online Payment System. Additionally, many clients find it easier to keep a credit card on file with us. You may choose the debit schedule that meets your needs and obligations. Contact the CTP billing department to discuss these options.

CREDIT CARD USE AUTHORIZATION FORM
You may keep your credit card information on file with our office. To do this, please complete the Credit Card Use Authorization form found later in this Handbook or contact the CTP billing department to request this form.

RETURNED CHECKS
There is a $35 insufficient check funds charge for each returned check. This charge is to be paid in addition to your regular therapy charge and is due prior to your next therapy appointment.

CREDITS TO YOUR ACCOUNT
Any monies collected from your insurance company after personal payment has been made will be credited to the remaining account balance or refunded to you. This does not include co-payments.

CANCELLATION AND NO SHOW CHARGES
Due to scheduling needs, we require a 24-hour notice for cancellations and/or rescheduled appointments. A $25 charge will be assessed to your account for missed appointments or cancellation with less than a 24-hour notice. This charge cannot be billed to your insurance company or Medicaid. It is solely your responsibility to pay these charges.

Children's Therapy Place

AUTHORIZATION FOR PAYMENT

Insured's Name ____

Name of Insurance ____

Insurance ID Number ____

Insured's Date of Birth ____

Insured's Policy Group or FECA Number ________________________________

Employer's Name or School Name ___________________________________

Insurance Plan Name or Program Name ________________________________

**** Please submit a copy of your insurance and/or Medicaid card(s) ****

Is there another health benefit plan? ________ Yes ________ No

Secondary Plan of Insurance ____

Insured's Name ____

Insurance ID Number ____

Insured's Date of Birth ____

Insured's Policy Group or FECA Number ________________________________

Employer's Name or School Name ___________________________________

Insurance Plan Name or Program Name ________________________________

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ___________________________________ DATE ______________________

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:

I authorize payment of medical benefits to Children's Therapy Place for therapy services received.

SIGNED ____

EXPEDITING YOUR INSURANCE BENEFIT COVERAGE BEGINS WITH YOU and may be the most important thing you do to maximize your insurance benefit potential. This means you must take an active role in coordinating your insurance plan benefits with our office, your benefits coordinator, and/or insurance company representative. Additionally, it means promoting the value of therapy services for you and for others.

10 STEPS TO MAXIMIZING BENEFIT COVERAGE

1. Know Your Policy

A. Is therapy a covered benefit under your plan? If so, what are the exclusions? Does your plan exclude certain problems or disorders?

B. Is your policy self-funded or fully funded? This makes a difference.

i. *Self-funded* plans are benefit packages designed by your place of work and may carry limitations. Example: coverage for accident or injury only, etc. They may also limit the number of available services to 20, 40, or 60 visits per calendar year. Each plan is different. Read yours carefully.

ii. *Fully funded* plans are those directly provided through insurance carriers. These plans carry limitations as well and limitations reflect the policy you purchase. Estimate your benefit needs when you purchase your plan.

C. Are more visits available to you when your initial authorization expires?

D. Is your plan an HMO, PPO, EPO, etc.? Plan benefits and expectations vary based on the plan product you purchase.

E. Do you have a deductible?

F. Do you have a co-insurance payment?

G. Have you discussed your policy benefits with Children's Therapy Place's office staff?

2. Know The Team Players

You are the team leader in charge of coordinating efforts to access your policy benefits. The members of your team include the referring physician, benefits coordinator, insurance plan representative, therapist, other related medical specialists and our office staff. Each person supplies a piece to the puzzle of successful coverage advocacy. You are the team leader. As such, it is your job to make sure that each team member performs their part.

- The *referring physician* provides primary medical information. He/she writes prescriptive orders for both evaluation and treatment services. He/she receives a copy of the evaluation and progress reports and serves as an advisor to you and your therapist.
- The *benefits coordinator* knows your plan benefits based on company policy decisions. This person will help you interpret your plan benefits and can serve as a coordinator with the insurance company if necessary.

2. Know The Team Players Cont.

- The *insurance plan representative* is usually a clerk responding to incoming calls at your insurance company. That person has access to basic plan information but cannot tell you if the services are truly covered or not. They have computer access to the status of authorizations and claims, but have no say-so in determining coverage.
- The *therapist* conducts an evaluation to determine the underlying cause of your concern. After the initial evaluation, test findings are recorded on the evaluation report that is reviewed with you. Copies are sent to your referring physician and to the insurance company with accompanying billing information. The therapist is responsible for coding your diagnosis through the use of standard billing codes called ICD-9 codes. These codes identify the underlying nature of the problem as clearly as possible. The therapist also writes support documents as necessary to assist with determining medical necessity and appeals.
- Other *medical specialists* may include medical or diagnostic specialists who contribute information relating to the condition. These reports help support the diagnostic findings and the need for services.
- Our *administrative staff* submits billings to the insurance companies, provides assistance to you during verification and authorization processes and files documentation with your insurance company as it relates to billings and appeals.

Visit with the team members and familiarize yourself with their supportive roles and input as it relates to the treatment plan.

3. Find A Mentor

Identify a person in your Human Resource department or a particularly helpful customer service representative at the insurance company. Ask how to contact them and speak to them directly when you need help.

4. Be Persistent

Call your insurance company daily if necessary to obtain authorization or appeals information. Make this a priority.

5. Document All Conversations

Make a note every time you talk to someone about your insurance concerns. Include the date of the conversation and the name of the person with whom you spoke. Identify them by their first name, last initial and/or reference #. Write a brief description of the pertinent facts of the conversation. Note: Insurance companies usually give first names only.

7. Make Your Voice Heard: Join Your Insurance Company's Benefits Coordinator In Selecting Policy Benefits

A. Never assume anything. Be prudent in investigating plan options prior to any plan changes.

B. Know when your insurance company changes benefit years. It varies from company to company and may happen in almost any month of the year.

C. Begin six months ahead of the benefit year change to lobby your insurance company for the maximum benefit package you feel is necessary to meet your therapy coverage needs.

D. Are there other people needing the same benefit? There is strength in numbers. Ask others about their insurance needs and be vocal about yours to them. They may also advocate on your behalf.

8. Pay Attention To EOBs and Statements

A. EOB stands for Explanation of Benefits. This is an account statement you receive monthly from your insurance company. Open them promptly and review payment considerations immediately. Call your insurance company with concerns and do it promptly. It is best to catch denials as quickly as possible. This helps manage your financial obligations.

B. CTP sends statements when there is action required on your account. Read the information carefully and call the billing department with any questions. The telephone number is (208) 323-8888.

9. Claim Denial Is Not A Final Determination

Insurance companies often deny services initially to delay payment responsibilities. Denial, however, is a *red flag* and requires immediate action.

10. You Can Appeal A Claim Denial– Know Your Rights

A. Identify the reason for the denial based on written information from your insurance company.

B. Discuss the denial with your therapist, physician, and our billing department.

C. Prepare the necessary appeals documents including:

- i. A letter of medical necessity from your physician
- ii. A support letter justifying the need for services from your therapist
- iii. Any supportive documentation from other healthcare professionals
- iv. All documentation associated with service denial including, but not limited to, reports, daily notes and billing documents

D. Submit your appeal to the proper place in a timely manner.

- i. Most denial letters indicate the time during which you may make an appeal and the place where the appeal is to be sent. Follow this information carefully.
- ii. Follow your submission with frequent telephone calls to the insurance company appeals department. This demonstrates your concern and it is true that the squeaky wheel gets the grease. Document your conversations.

E. You have the right to contact the Idaho Department of Insurance.

You may call (208) 334-4250 or go online to http://www.doi.state.id.us to seek assistance or file a complaint if you feel your insurance company is not meeting their obligations.

CREDIT CARD AUTHORIZATION

CTP offers the convenience of leaving a credit card on file to handle all co-payments and any applicable fees regarding your therapy. If you would like to utilize your credit card as a consistent form of payment, please fill out the section below and return it to the billing department. Thank you!

I authorize Children's Therapy Place to keep my signature on file and to charge my account for balance of charges not paid by insurance, Medicaid, and/or Katie Beckett within 60 days and not to exceed $________.

I understand that my credit card will be charged $25 for any missed appointments or cancellations with less than a 24-hour notification.

I understand this form is valid for one year unless I choose to cancel the authorization through written notice to Children's Therapy Place.

Circle One: Visa Mastercard Discover

Client's Name: ____

Cardholder's Name: ____

Cardholder's Signature: ____

Statement Address: ____

Cardholder's Email Address: ____

Credit Card #: ____

Expiration Date: ____

Security # (from back of card): ____

Banking Institution: ____

It is the policy of CTP, in compliance with the Health Insurance Privacy Accountability Act (HIPAA), that each client's information, written/verbal and each client's interactions, past or present, shall not be released without the signed permission of the client and/or the client's legal guardian. Information will only be exchanged with other CTP employees or individuals with signed releases of information who are actively involved in treatment services. In addition, clients and/or their legal guardian have the right to review all privacy notices before signing, have the right to requests and restrictions on disclosure, and have the right to revoke consent.

In an effort to protect our clients' privacy, we ask that siblings or children that accompany another child to an appointment stay in the waiting room and be supervised by an adult at all times. We request no food or beverages in the office and that cell phones are kept on vibrate while in the waiting room.

Exceptions to Confidentiality
There are exceptions to complete confidentiality with which CTP must comply. Some of these exceptions include child abuse, suicidal clients, tarasoff 'duty to warn', joint custody decrees, Guardian Ad Litems, Crime Victim Compensation Program, and subpoenas. CTP is required to report to the appropriate authorities when any of these circumstances are disclosed or present themselves.

Confidentiality Notice
Our office requires you to sign a notice of your rights regarding confidentiality standards. This form should be completed and returned on the day of your child's evaluation or treatment session.

Release of Information
Our office requires you to sign a records release form so we can share pertinent diagnostic, treatment, and billing information with your doctor, insurance company, school, etc. This document also allows us to request previous therapy and medical records as necessary. The form should be completed and returned on the day of your child's evaluation or treatment session.

Coordination of Services
CTP will do everything possible to coordinate the services you receive with other agencies and care providers when requested. Please make sure to tell your therapist or an administrative staff member if you would like your records, including but not limited to progress notes and evaluations, shared with your physician or classroom teacher.

Children's Therapy Place
Acknowledgement of Confidentiality Policy

New Patient Consent to the Use and Disclosure of Health Information for Treatment, payment or operations.

I, ______________________________, the parent/guardian of ______________________________ understand that as part of my child's services, CTP originates and maintains paper and/or electronic records describing my child's service history. I understand that this information serves as:

- A basis for evaluation and therapy treatment,
- A means of communication among the many health professionals who contribute to my care,
- A tool for assessing quality and reviewing the competence of therapists.

I am aware that CTP has a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I may request a copy of the Notice if I so desire. I also understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my child's information for directory purposes, and
- The right to request restrictions as to how my child's information may be used or disclosed to carry out
- treatment, payment, or therapy operations.

I understand that CTP is required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that CTP reserves the right to change its notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. I may request a revised Notice of Privacy Practices at any time by calling the office and requesting a copy or by asking for a copy at my next visit.

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

____ ___________________________

Parent/Guardian's Signature Date

CHILDREN'S THERAPY PLACE
AUTHORIZATION FOR DISCLOSURE

Client Information

Client Name____Date of Birth_________________

Mailing Address____State__________Zip Code________

Requestor Information to be completed if authorization is being made by someone other than the subject of the information.

Requestor Name_____Children's Therapy Place, Inc._________Telephone___(208) 323-8888_______

Relationship________________Therapy Provider____

Address________6855 W Fairview Ave Boise_________________State____ID___Zip___83704____

Authorization Details

I authorize the following ____

To disclose this confidential information to______Children's Therapy Place, Inc._________________

Address________6855 W Fairview Ave Boise_________________State____ID___Zip___83704____

Fax__(208) 323-8889______________________Phone____(208) 323-8888_____________________

For the purpose of ______Therapy____

Please describe in detail the information to be disclosed

____

____

____

I understand that, at my request, a copy of the completed and signed authorization form will be made available to me. I understand that I may revoke this authorization in writing, at any time, except to the extent that action has been taken in reliance upon this authorization.

____

Signature Date

Say Cheese!

Children's Therapy Place

We want to take your picture! This form is optional. It is a request, not a requirement.

- CTP has the unique ability to scan your child's picture onto documents associated with his/ her care. This makes your child a smiling face rather than a name or account number.
- Your picture may also be used to promote services through posters, flyers, brochures, etc. We feel the best way to do that is to present snapshots of real clients participating in the therapy process.

Consent to Photograph/Videotape

I, the parent/guardian of ____ hereby give Children's Therapy Place, Inc, its agents, and/or assignees permission to use the photographs, motion pictures or any reproductions of my child's physical likeness taken of him/her in any manner it deems proper. I relinquish all rights, title, and interest I may have in the finished pictures, negatives and copies. I waive the right of prior approval and hereby release Children's Therapy Place, Inc, its agents, and/or assignees from any and all claims from damages of any and all kinds based on use of said material. I am of legal age and freely sign this release, which I have read and understand.

____ _______________

Signature Date