THE TALCOTT CENTER FOR child DEVELOPMENT

230 Farmington Ave, Farmington, CT 06032
www.thetalcottcenter.com contact@thetalcottcenter.com

Client's Name: _____ Date: _____

Clinical Policies Agreement

The following is a description of THE TALCOTT CENTER FOR CHILD DEVELOPMENT, LLC (TCCD) policies. Please read and indicate you agreement to abide by these policies by initialing and signing where indicated. If you have any questions about these policies, please talk with our Clinic Director before signing.

Evaluation and Initial Assessment Policies
All new and returning clients seeking individual services at the center are required to have either an initial evaluation or clinical assessment on file. An assessment/evaluation completed by an outside clinician may be utilized by TCCD if it is completed within 3 months of the commencement of services at TCCD and provides sufficient clinical documentation to develop an appropriate plan of care. If you are seeking reimbursement by your insurance company, a re-evaluation may need to be completed by TCCD in order to seek current coverage. Please allow 2-4 weeks to receive a copy of your child's written assessment, following the last day of their evaluation.

I have read and agree to and abide by the above policies. *Initials* _____

Treatment and Scheduling Policies
I understand that in order to receive the maximal benefit from treatment, it is important for sessions to occur each week. I understand that for sessions cancelled with less than 24- hour notice of my scheduled appointment, a cancellation fee of $60 will be charged. I understand that if sessions are canceled with more than 24- hours' notice, I will not be charged a cancellation fee; however, this clinic encourages scheduling a make-up for these and all other sessions in order to ensure optimal progress. If no cancellation notice is given and the scheduled appointment is missed, I will be charged $60 for the missed session. Payment for missed and cancelled visits is expected prior to or on my child's next scheduled appointment. I understand that these fees for missed or cancelled services are not reimbursable by insurance and I agree to payment of these fees. In addition, I understand that this clinic has the right to terminate services should sessions be inconsistent due to frequent cancellations, no shows, should home strategies recommended by my therapist not to be carried through with, and/or should my payments for missed appointments not be made within the allotted time period.

I understand that when our therapist is ill or on vacation, the clinic will do their best to provide a substitute therapist to ensure continuation of services. I am aware that TCCD employs clinicians who are skilled in treating my child and that a substitute therapist will be provided with details on my child's treatment. In

addition, I am aware that TCCD encourages my child to work with varying clinicians, as it provides insight into my child's care, fosters collaboration and ensures that my child is receiving the optimal level of care.

I have read and agree to and abide by the above policies. *Initials*_____

Office Policies

I understand that infants and toddlers often need to be accompanied by a parent during treatment; all other individuals are asked to wait in the waiting room during treatment sessions. Observations of my child's treatment session by individuals other than parents or guardian may be scheduled upon request.

I understand that I am responsible for waiting with my child in the waiting room until sessions begin and for monitoring my child's play in the waiting room. I understand that this clinic prefers I wait during the session so that I am available to watch parts of my child's treatment when appropriate or for assistance as needed. If I leave during the treatment session, I understand that I am responsible for notifying clinic staff of my destination so that the clinic knows my whereabouts in the event of an emergency. I understand that I am responsible for returning for my child 5 minutes before the close of the treatment session. I understand that I may be required to stay in the waiting room for my child's entire session if my therapist has concerns regarding the well-being of my child, other clients, or themselves.

I have read and agree to abide by the above policies. *Initials* _____

Acknowledgement of Risk

I acknowledge that there is some risk inherent in the use of the therapy equipment at this clinic, and I agree to indemnify and hold TCCD harmless from any and all losses and claims for any injuries or other damages occurring to myself or my child or our belongings from the use of therapeutic equipment. I am aware that TCCD has established rules of safety and conduct and both the center and I agree to fully abide these standards.

I have read and agree to abide by the above policies. *Initials* _____

Assignment of Benefits

I hereby authorize The Talcott Child Development Center to release all information necessary concerning my medical condition to secure proper payment, and hereby assign the payment for services rendered. I understand that I am responsible for all charges whether or not paid by my insurance. This assignment will remain in effect until revoked by me in writing.

I have read and agree to abide by the above policies. *Initials* _____

Financial Policies

I have initiated services and understand that payment is due at the time services are rendered. If a school system or insurance carrier has authorized direct billing, I understand that my bill will reflect only that amount not covered or authorized, which is due from me. I understand that this clinic may bill my insurance company directly at my request only when all of the proper insurance information and pertinent

documentation is on record in the billing office. I understand that I am responsible to provide any required insurance deductibles, co- payments or coinsurances at the time services are rendered.

While I may carry insurance benefits, it does not guarantee payment of services. TCCD will do their best to determine my child's coverage and secure coverage. However, I understand that if a claim submitted directly by this clinic to my insurance company is not paid within 45 days of submission, the balance becomes due immediately from me. At that time, I will be contacted by the TCCD front office to make arrangements for payment of the balance due. Should payment be later reimbursed to the clinic by my insurance carrier, I understand that I will be refunded the paid amount. Should I not remit payment for services according to the clinic guidelines, I understand that services may be ceased until payment is made by me. I understand that during this time, the clinic will not be able to hold my child's schedule therapy time slot. If I am paying by check, any returned checks are subject to a $30 fee.

I have read and agree to abide by the above policies. *Initials* _____

Optional Policies

Education and Training

TCCD is a strong supporter of higher level learning among the therapy community. TCCD works in strong collaboration with college based programs and our site is utilized for student internships. These internships range from volunteer hours, to higher level treatment internships. Level II internships for therapy students are required as part of their graduate studies, and are utilized in order to provide them with hands on training in their profession. These students work underneath the careful guidance of our skilled therapists as they work in collaboration with your child.

I give permission for college therapy students and volunteers to observe my child's therapy sessions.

Initials_____

I give permission for college fieldwork students to participate, develop and implement treatment sessions under the guidance of my child's therapist, as appropriate.

Initials_____

Photos/Videos

I give permission for photographs/videotapes to be taken of myself for my child for educational and/or marketing purposes (i.e. website, brochures, etc.), or display within waiting room.

Initials_____

I give permission for my child's therapy sessions to be videotaped to monitor his or her progress.

Initials_____

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Signature Date