Winsome Therapy Clinic

info@winsometherapyclinic.com

Learner Information

Last Name:	First:	MI:	Gender:	Date of Birth:
Street Address :		City:	State:	Zip :
		Age:		

Parent/Caregiver Information

Last:	First:	MI:	Relationship to learner:
Street Address:		City:	State: Zip:
Email Address:	Phone Number:		Occupation:

Insured's information

Last Name:	First:	MI:	Gender:	Date of Birth:
Street Address :		City:	State:	Zip:
Relationship to the learner:		Employer:		
Insurance Plan Name:	Participant/Member ID#:	Group ID #		

Physical insurance card is required for copying at the first appointment

I declare the above information is true and correct

_____ Date _____

Patient Name

_____ Date _____

Signature (parent or guardian if patient is under 18 yr old)

Winsome Therapy Clinic

info@winsometherapyclinic.com

ACKNOWLEDGMENT OF RISK

In consideration of the services of Winsome Therapy Clinic LLC. their officers, agents, employees, and stockholders, and all other persons or entities associated with those businesses (hereafter collectively referred to as “WTC”) I agree as follows: Although WTC has taken reasonable steps to provide me with appropriate equipment and skilled guides so I can enjoy an activity for which I may not be skilled, WTC has informed me that this activity is not without risk. Certain risks are inherent in each activity and cannot be eliminated without destroying the unique character of the activity. These inherent risks are some of the same elements that contribute to the unique character of this activity and can be the cause of damage to my equipment, or accidental injury, illness, or in extreme cases, permanent trauma or death. WTC does not want to frighten me or reduce my enthusiasm for this activity but believes it is important for me to know in advance what to expect and to be informed of the inherent risks. The following describes some, but not all, of those risks. The hazards of walking on uneven terrain, slips and falls; slipping and falling on the rock wall, crashing on the trampoline, falling from the swing, being hit by a ball or a toy, falling from a chair, choking, allergy reaction; my own physical condition and the physical exertion associated with their activities.

I am aware that WTC’s activities may entail risks of injury or death to any participant. I understand the description of these inherent risks is not complete and that other unknown or unanticipated inherent risks may result in injury or death. I agree to assume and accept full responsibility for the inherent risks identified herein and those inhering risks not specified. My participation in this activity is purely voluntary: no one is forcing me to participate, and I elect to participate in spite of and full knowledge of the inherent risks. I acknowledge that engaging in this activity may require a degree of skill and knowledge different from other activities and that I have that responsibility as a participant. I acknowledge that the staff of WTC has been available to more fully explain to me the nature and physical demands of this activity and the inherent risks, hazards, and dangers associated with this activity. I certify that I am fully capable of participating in this activity. Therefore, I assume and accept full responsibility for myself, including all mirror children in my care, custody, and control, for bodily injury, death, or loss of personal property and expenses as a result of those inherent risks and dangers identified herein and those inherent risks and dangers not specifically identified, and as a result of my negligence in participating in the activity, I have carefully read, clearly understood, and accepted the terms and conditions stated herein and acknowledge that this agreement shall be effective and binding upon me, my heirs, assigns, personal representative, and state and for all members of my family, including minor children.

IF THE PARTICIPANT IS A MINOR UNDER 18 YEARS OF AGE’

I, as a parent or guardian of (of minor's name)_____

hereby give permission for minor to participate in the activity and further agree, individually, and on behalf of minor to the above terms.

Parent/Gardian Name _____

ParentGardian Signature_____

Date _____

Winsome Therapy Clinic

info@winsometherapyclinic.com

ATTENDANCE POLICY

Appointments are scheduled into available standing appointment slots. Once you have been scheduled into an appointment time, the therapist has committed this time to you. All scheduling must go through the info@winsometherapyclinic.com.

It is the primary goal of Winsome Therapy Clinic to provide effective and quality services that are consistent to individuals and their support systems. Because we must ensure that your child is staffed 1:1 by your ABA member each day, cancellations result in staff overages. Our ABA staff rely on their work schedule and last-minute cancellations do not allow them to fill their work schedule elsewhere.

We recognize that sessions may need to be canceled for a variety of reasons such as but not limited to:

- Client cancellations
- Staff cancellations
- Sickness
- Tardiness
- Sessions ending early
- Holidays
- Emergencies

While circumstances outside of our control occur and result in last minute schedule changes, it is the expectation that monthly session adherence will be at or above 90% of all scheduled sessions.

If an individual falls below 90% attendance in any given month, a meeting will be scheduled with the treatment team including guardians to discuss the current schedule and extenuating circumstances. If attendance remains below 90% in any of the following three (3) consecutive months, a 2nd meeting will be scheduled to discuss the following:

- Changes to current schedule
- Reduction of service hours
- Services being put on hold (until a new schedule and/or long-term solution is identified)
- Termination of services (30- day notice, discharge plan, and referrals will be provided)

Winsome Therapy Clinic

info@winsometherapyclinic.com

Patient Name _____

Authorization for treatment

I consent to the treatment necessary for the above named patient, including applied behavior analysis, and any other services that the provider or physician advises to be necessary.

Payment/Insurance Authorization

I authorize all insurance payments to be made directly to Winsome Therapy Clinic LLC for therapy services rendered. I acknowledge that I am financially responsible for all charges not covered by this assignment. I further acknowledge that my insurance company may limit therapy benefits. I will be responsible for all charges accrued if my insurance denies services. I authorize Winsome Therapy Clinic LLC to release to the Social Security Administration, its intermediaries or carrier's information needed for the claim.

If a patient's outstanding bill reaches $ 700.00 (or more) therapy sessions can be placed in HOLD effective immediately. Patients treatment time will be held for 2 weeks to allow for the outstanding bill to be paid down 50% after which, treatment will resume. If the bill is not paid down to 50%, patients will be removed from schedule.

Private pay rates are available for families with no insurance/inactive insurance or with insurance that does not cover services. Please email info@winsometherapyclinic.com for more information. Private rates are not available to families that have active insurance.

Thank you!

_____

Please Print Parent/Guardian

_____

Signature (parent or guardian if patient is under 18 yr old)

Date _____

Winsome Therapy Clinic

info@winsometherapyclinic.com

Patient Name _____

HIPPA Consent

I give Winsome Therapy Clinic LLC my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations such as quality reviews. Communication may be included, but not limited to hospital, medical service company, health care company, insurance company, workers compensation carrier, welfare departments, patient's employer, previous therapy clinics, school teachers/aids/administration. I have been informed that I may review the practice/clinic's notice of privacy practices for a more complete description of uses and disclosures before signing this consent. I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic. I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

All information obtained will be kept private and used only for planning of services or for billing for services provided.

Please list the names of service providers that may be contacted by Winsome Therapy Clinic LLC

Provider Name	Type of Provider (Physician, school, other therapists, Early Intervention Services….)

Thank you!

_____

Please Print Parent/Guardian

_____

Signature (parent or guardian if patient is under 18 yr old) Date _____