



## Policies and Parent Contract

Client's Name:

### Please read and then initial

I am agreeing to return all requested paperwork to My Pediatric O.T. Services @ 1776 Washington Street in Walpole, MA, 02081, within 10 days of my referral (fax or email is an option; Fax # 508-337-8438). This will enable us to move forward with the scheduling process (more options coming in Jan 2023!).

Initial

A \$75 registration fee is required upon referral and submission of paperwork. This registration fee covers review and processing of all new-patient information by our office admin, referral coordinator, and the evaluating therapist. Registration fees can be collected via check or credit card –please check the option that you'd like to use, below. All payments to My Pediatric OT can be made with a credit card on file but weekly payments with a check is also an option and actually preferred.

- I am mailing a \$75.00 check made payable to My Pediatric OT Services along with this form.
- I would like the \$75.00 registration fee to be charged to my credit card, as listed on the submitted credit card authorization form

Initial

Our cancellation fee applies if the appointment is **cancelled with less than 12 hours notification or failing to show up to your scheduled appointment**. However, we do wish to reschedule ALL canceled appointments and avoid charging this fee and so you will be asked if rescheduling within 14 days is possible and we will accommodate if possible. Planned cancellations are also offered a makeup appointment as our ultimate goal is to achieve consistency and progress.

Initial

Although we do understand exceptions may apply, especially in the case of children, treatment sessions need to be cancelled a minimum of **12 hours prior** to the appointment in order to avoid a \$75.00 cancellation fee.

Initial

I understand it is expected that therapy session attendance is consistent as this is most beneficial to my child showing progress and meeting goals. If my attendance is less than 90% over 8 weeks I will need to discuss the schedule with my therapist and the potential move to a flex schedule.

Initial

**1776 Washington Street, Walpole, MA 02081**  
**(508) 208-8438 [www.mypediatricOTservices.com](http://www.mypediatricOTservices.com)**

I understand it is **required that I return and am available in the waiting room a minimum of 20 minutes prior to the end of the session.** Initial

I understand that if I opt for a written evaluation report, it will be available 3 – 4 weeks after the evaluation session(s). The cost of the evaluation report is \$325, which is not covered by insurance. The cost of this optional report will cover the therapist’s time (insurance companies cover time with the child administering the evaluation, but do not reimburse time scoring and writing the report which takes an average of 3 additional hours to complete).

I am **interested** in having an evaluation report completed for my child. Initial

I am **NOT interested** in having an evaluation report completed for my child. Initial

I understand an **additional fee** will apply towards certain administrative requests. Initial

If applicable, I understand I need to be available to provide **toileting assistance** for my child. Initial

As part of the My Pediatric OT Services team, I understand the importance of establishing and following through with my child’s home program as this is expected to ensure progress is being made and attainment of goals. Initial

I understand that a physician’s referral may be needed in order to obtain authorization for Occupational Therapy services. Prior to my child’s appointment, **I am responsible for contacting my insurance company to attain referral/authorization as needed. Any preauthorization number can be emailed to MyOTServices@gmail.com or included in the paperwork packet (pediatrician may fax to 508-337-8438).** Initial

I understand if there is a **change in my insurance coverage or plan** I need to notify My Pediatric OT Services immediately to ensure session coverage and avoid incurring any session fees due to lack of insurance coverage. Initial

Parent/Guardian:

Signature: \_\_\_\_\_ Date: