503.352.0240
Fax 503.352.0242
www.nhws.us

NEW HORIZONS
WELLNESS SERVICES, LLC

9400 SW Beaverton-Hillsdale Hwy.,
Suite 210, Beaverton, Oregon 97005

Clinic Policies

Please read the following policies. Keep one copy of this document for your records and return a signed and initialed copy to the office to be kept in your patient file.

Treatment Sessions
Half hour sessions of therapy are equal to twenty-five (25) minutes of therapy. Forty-five minute (45) sessions of therapy are equal to forty (40) minutes of therapy. One hour sessions of therapy are equal to fifty-five (55) minutes of therapy. The last 5-10 minute of the sessions are dedicated to discussing the treatment session with the parent. _____ (Initials)

Payments and Billing
Payment for service is due at the time services are rendered. The individual who brings the patient to therapy is responsible for payment of the therapy session. Please make all checks payable to New Horizons Wellness Services. Please note, there will be a $40.00 charge for all returned checks. The credit card receipt provided at the time of services is your receipt. Statements are provided upon request only. _____(Initials)

Scheduling/Participation
In order for your child to reach his/her established goals in their treatment plan, it is imperative that your child attend his/her regularly scheduled visit. We at NHWS ask you to be mindful of this. We are aware that unanticipated emergencies (e.g. illness, vacations) take place. However, your child needs as much consistency as possible. We require our children to maintain a 75% attendance rate at their regularly scheduled time in order for them to continue to make progress. If appointments are not maintained on a consistent basis, we may have to move your child to a different treatment time. _____ (Initials)

No Shows, Late Cancellations
Our professional standard is to begin and end each session in a timely manner. Therefore, our expectation of our clients is that they will be punctual so that we are optimizing our appointments to the patient's benefit. Appointments follow a specific treatment plan for each patient. As such, patient's arriving more than 10 minutes late may be rescheduled and charged a late cancellation fee. Patients arriving more than 15 minutes late are considered No Shows unless other arrangements have been made. Certainly, we understand that there are exceptions to this policy, such as sick children and family emergencies, which are not possible to control. We simply ask that you be as mindful as possible of your therapist's schedule. Please note that it is your responsibility to contact our office as soon as possible to eliminate any extra fees. You may also contact our office at the number above and leave a message after hours. _____ (Initials)

Appointments that are not cancelled are considered a No Show. Patients arriving more than 15 minutes late for their scheduled appointment are considered No Shows. No Show appointments are charged the full rate of the scheduled therapy session. _____ (Initials)

Late Cancellations:
We request 24 hours' notice for a cancelled appointment in order for our therapists to have the opportunity to adjust their schedule accordingly. An appointment that is not cancelled at least 24 hours prior to the

scheduled appointment time is considered a late cancellation and clients will be charged full fee for the scheduled therapy session. _____ (Initials)

Late Patient Pick-Up:
The late pick-up fee is $35.00 for every 15 minutes. NHWS cannot accommodate children that are left unattended as our therapists must go on to the next scheduled appointment. If you leave the clinic during the patients' session, please return five minutes prior to the conclusion of the session. We are mindful of those circumstances that are unavoidable. If an emergency occurs, please contact the office as soon as possible so that the NHWS staff can make accommodations for the patient. _____ (Initials)

Notice to Discontinue Treatment
If you choose to discontinue therapy services, you will need to provide 30 days notice prior to your last session. NHWS is willing to accommodate two week prior notice for unique circumstances which will be determined on an individual basis. If you choose to discontinue services before clinically indicated, we require notice in order to allow appropriate termination of service including but not limited to: allowing time for any retesting that may be necessary to summarize the child's program and progress, provide a home program specific to the needs of the child, and adequate time to compile documentation for referral and reimbursement providers. Cancellation of therapy services must be received in writing (verbal cancelations will not be accepted). If the proper notice is not provided, you will be held financially accountable for up to four weeks of therapy services at the full rate if not covered by your insurance carrier. _____ (Initials)

HOLD Policy
It is for the benefit of the patient that they receive consistent treatment and are present for their scheduled therapy sessions. We understand that certain personal situations may require that the patient have a short absence from therapy services. NHWS is able to put your child on HOLD for a maximum of **four weeks** during which their treatment following the absence is secured. If the patient is on HOLD for a duration greater than **four weeks**, the patient will then be discharged and full testing will be required to resume treatment. All requests to be put on HOLD must be received in writing (verbal requests will not be accepted) _____ (Initials)

Feeding Policy
Patients who are involved in feeding appointments: Parents will be responsible for providing the correct food items that the therapist suggests for the patients. Therapist will not be responsible for providing food. If therapists do provide food, NHWS will charge a $25.00 monthly fee to cover expenses. _____ (Initials)

Clinic and Waiting Room Manners
The care and safety of children and/or siblings that accompany you to the patient's session are your responsibility. In addition, a patient's safety is the responsibility of the parent or guardian when not accompanied by a therapist. For their protection, children are not allowed in other areas of the clinic unless escorted by a parent or guardian.

Children in the waiting room are the responsibility of the parent or guardian. We ask that you please monitor your child in the waiting room and respect the property of NHWS and the other families in the reception area. At times seating can be limited in the waiting room, please allow adults to sit down. We make every effort to keep our waiting room clean and tidy. If you bring snacks and/or drinks into the waiting room, please keep the area clean of any spills. We greatly appreciate the use of lidded cups. Please supervise your children in the restroom.

Due to HIPAA regulations, we are not allowed to invite parents or guardians or siblings into the treatment area unaccompanied by a therapist and/or if another patient is being treated in the same area. Thank you in advance for your courtesy. _____ (Initials)

Patient Care

New Horizons Wellness Services shall provide occupational and speech therapy services and materials in compliance with the orders of the patient's attending physician. Administration of treatments will be delivered as ordered by said physician.

- **Consent to treatment:** Patient and/or patient's representative acknowledge that the patient is under the medical treatment and care of said attending physician, and that NHWS renders its services to the patient under the general and specific instructions of said physician. The patient and/or patient's representative recognizes that said physician furnishing services to the patient is an independent agent and is not an employee or contractor of NHWS.
- **Restrictions and liabilities:** NHWS shall incur no liability for injuries of any kind suffered by the patient while under care; therefore, should the patient discontinue treatment before the attending physician has so ordered, the patient and/or patient's representative agrees to assume all responsibility for all results which follow.
- NHWS is not liable for injury to the patient caused by visitors attempting to assist or treat the patient in any way. For the safety of the patient and others, on the patient and the patient's guardian, if a minor, are permitted in patient treatment areas. _____ (Initials)

Financial Agreement

Insurance Policy:

New Horizons Wellness Services (NHWS) is an in-network provider with Blue Cross Blue Shield (BCBS), United Healthcare (UHC), Aetna, Cigna, Moda, Pacific Source, FamilyCare and files out-of-network insurance claims with Providence. Please notify us if your insurance company is not listed and we will research our ability to file your claims and provide treatment under your insurance plan.

Patients are required to pay their annual out-of-network or in-network deductible at the beginning of their plan's calendar year. After the patient's out-of-network or in-network deductible had been satisfied, the patient is responsible for the co-pay or co-insurance amount set by their insurance carrier. Any non-covered services are the financial responsibility of the patient. Co-payments, co-insurance, non-covered services and/or deductibles are the responsibility of the patient and are payable at the time of service.

In the event that payment for a performed service is denied by the insurance carrier, it is the patient's responsibility to pursue action with their insurance carrier, as the policy is a legal contract between the patient and the insurance company. _____ (Initials)

Medicaid:

FamilyCare participants are exempt from our insurance policy. If your child does receive additional services, please notify us immediately. The requirements in order to be accepted and maintained will be mandatory attendance and cancellations with at least 24 hour notice. Two (2) no shows will result in the discontinuation of the services. _____ (Initials)

For other Carriers, there is no insurance coverage:

If a patient has insurance carriers other than Blue Cross Blue Shield (BCBS), United Healthcare (UHC), Aetna, Cigna, Moda, Pacific Source or has no insurance coverage, they are responsible for all charges incurred at the time of services. Co-payments, Co-insurance, non-covered services and/or deductibles are the responsibility of the patient and are payable at the time of service. _____ (Initials)

Visit Limits:
Visit limits are set by your insurance carrier. If your insurance policy has visit caps or limited visits, it is your responsibility to track these visits as they occur. If you have participated in any therapy services with another provider during the insurance year, then you will need to include those visits. NHWS will do our best to keep track of these visits, but it is the patient's responsibility to manage the visits overall. This is especially important if the child is received additional services such as speech therapy, physical therapy, etc. _____ (Initials)

Patient Release for Interns and Volunteers
NHWS is a teaching clinic so on occasion student interns from various colleges may accompany your child's therapist, observe treatments, and have sight of their notes. A background check through each respective institution is conducted for each student intern. NHWS periodically allows volunteers to assist in the clinic. They will be in the treatment area with your child under the supervision of your child's therapist. Each volunteer has HIPAA privacy instructions. Volunteers are in place to learn and assist the therapist in the treatment of the patient and work for the benefit of patient's care. Volunteers are not employees of NHWS and cannot assist you with billing, scheduling, medical or insurance information.

By signing, I understand that my child's treatment, testing, evaluations, daily notes and/or invoices will be seen by student interns in training to become Occupational Therapists, Speech Pathologists, and by volunteers. I understand that the student interns and/or volunteers will be involved in the treatment of my child. _____ (Initials)

Adult Patients
If the patient is 18 or over it is necessary that New Horizons Wellness Services receive either proof of guardianship or permission from the patient to share any details regarding evaluation or treatment (orally or through written documentation) with parents or other family members. This is in reference to legal policy regarding privacy laws/confidentiality, in addition to the privacy polices of NHWS. If legal guardianship is not provided, the patient must fill out and sign an Authorization To Use and Disclose Protected Health Information form prior to any discussion of services with those other that the patient (verbal consent will not be acceptable). _____ (Initials)

Photo/Video/Website/Print Consent
I authorize NHWS to use my child's photo(s) in our brochures, printed materials, and in the clinic, my child's photo(s) and/or video(s) on our website for the use of public relations, promoting various NHWS occupational therapy programs. I understand that I will be notified before the use of the photo(s) and/or video(s). _____ YES (Initials) _____NO (Initials)

Contacting Your Therapist
Please note that telephone calls are answered between **9:00 am - Noon** and **1:00 - 5:00 pm**, Monday through Friday. We are generally closed on Fridays during the summer months. Messages may be left on our voice mail system. We will make every effort to return your call on the same day you make it, or at least within 24 hours, with the exception of weekends and holidays. **Electronic communication, (email), presents a potential risk to patient confidentiality.** While patients and/or parents may find this a convenient way to communicate they must be aware of the risks. We will respond should you choose to email us regarding non-clinical issues such as appointment scheduling. **Please note we will not engage in "therapy" nor respond to casual "chats" via email.** Information exchanged by fax/email will become a part of the clinical record.

Therapy Dog Consent

I authorize NHWS to use a therapy dog in therapy session as part of my child's treatment. I understand that my child will never be left alone with a therapy dog.

_____ YES (Initials) _____ NO (Initials)

Joint Custody Payment Policy

NHWS cannot divide credit card payments for children of divorced parents. NHWS's policy requires that the parent or guardian who brings the child in for services be financially responsible for payment of treatment services unless other arrangements are made in advance through the business office. Parents may pay separately by check but payment must be made in full. For credit card payments, only the signatures of the cardholders present at the appointment are allowed. There are no exceptions to this policy. _____ (Initials)

BY SIGNING THIS DOCMUENT, I UNDERSTAND THAT PAYMENT IS EXPECTED AT THE TIME OF SERVICE. I MUST PROVIDE A PHOTO COPY OF MY INSURANCE CARD ANNUALLY AND ANY TIME I CHANGE INSURANCE PLANS. IT IS MY RESPONSIBILITY TO NOTIFY NHWS OF ANY CHANGES. I UNDERSTAND THAT I MAY BE RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY HEALTH PLAN.

_____ (Initials)

Your signature below validates your initials on each of the clinic polices described above. We appreciate our time and effort in completing these forms. Accurate patient documentation is necessary for NHWS to protect our patients' rights.

_____

Patient's Name

_____ _____

Parent /Guardian Signature Parent/Guardian Name (print)

_____

Date

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Clinic Wellness Policy

Please do not bring your child (patient or sibling) into the clinic if they are exhibiting any of the following medical health concerns:

Fever: Fevers are common in young children and are often a signal that something is wrong. If your child has a fever of 101 F or higher, please keep him/her at home. If your child develops a fever of 101 F or higher while at the clinic, the therapy session will end and your therapist will make every reasonable effort to reschedule the appointment. Our policy is that your child must remain fever-free for 24 hours before returning to the clinic, a policy agreed upon by local pediatricians. The 24 hours begins when your child's fever has broken and remains in the normal range.

Diarrhea: Diarrhea due to illness is highly contagious. If your child has diarrhea, please keep him/her home. Please understand that germs from diarrhea can spread throughout carpet, toys, swings and direct contact. It is very difficult to keep these germs from spreading to other children. However, if this is a chronic condition for your child, please advise your therapist so that we can make the appropriate recommendations or accommodations.

Vomiting: If your child vomits while at the clinic, you will be called to pick him/her up immediately. Please keep your child at home for 24 hours after the vomiting has stopped. When children return to therapy prematurely, there is a much higher rate of recurrence and contagiousness.

Severe Common Cold: Symptoms include, but are not limited to: bad cold with a hacking or persistent cough; green or yellow nasal drainage; and/or a productive cough with green or yellow phlegm. These symptoms may be present with or without a fever. Seasonal allergies are exempt from this policy.

Rash: A rash may be a sign of many illnesses such as measles or chicken pox. Please do not bring your child into the clinic until your doctor releases you to do so. Rashes due to non-contagious skin conditions are exempt from this policy.

We do understand and empathize with parents when their children are ill. These policies are designed to be fair to the ill child and their family, as well as the healthy children and their families. Please understand that we love our children and strive to provide the best possible care for them. We hope to control the amount of illness at the clinic and to keep everyone healthy and happy. If you have any questions or comments, please do not hesitate to call us. Thank you!

_____ _____

Printed Patient's Name Date

_____

Printed Parent/Guardian Name