CONSENT FOR PARTICIPATION/ INFORMED CONSENT WAIVER

Therapy conducted with Sensational Play LLC and Sensory Play LLC, Treehouse Pediatric Therapy LLC, and independent contractors hired by Treehouse Pediatric LLC (together, the "LLCs" and each individually, an "LLC") may include exercise play on therapy equipment including swings, exercise balls, children's toys and other gross and fine motor therapy activities. Therapy may also involve feeding and play activities with a variety of textures, scents, solids and liquids. **Initial _____**

It is necessary to get your permission to allow_____ (print patient's name) to participate in the speech-language therapy, occupational therapy, summer camps, group programs/group therapy provided by the LLC's at your child's preschool/school, in your home environment, and/or at 12201 Gayton Road, Henrico VA 23238.

I, _____ (patient or parent/guardian) here by release the LLCs and/or independent contractors hired by Treehouse Pediatric Therapy, LLC from any liability, claims, demands, & causes of action, now or in the future, resulting from soreness, illness, or injury however caused, occurring during or after my child's participation in the therapy programs and group programs. I acknowledge that each individual LLC and independent contractor is individualized and not responsible for the services, actions, outcomes, or liabilities of the other LLCs. **Initial_____**

In signing this Consent for Participation/Informed Consent Waiver, I hereby affirm that I have fully read the above statements & understand the inherent risks involved with participation in speech-language therapy, occupational therapy, feeding therapy, nutritional/dietary services, summer camps/groups, and group therapy with one or more of the LLCs at the child's preschool/school setting, the child's home environment, or 12201 Gayton Road, Henrico VA 23238 and agree/give permission for my child to participate. I have been informed of the risks and complications that may occur and alternatives that may be available. I acknowledge that no guarantees or assurances have been made to me/ my child concerning the results intended from the treatment, camps and/or programs. **Initial _____**

In signing this document, I hereby affirm that I have read and fully understand the above statements.

Parent or Guardian Signature: _____Date: _____

Patient Signature (Over 18): _____Date: _____

Signer's Printed Name: _____

Parent/Guardian Name:_____

Client's Name: _____ DOB_____

Address: _____

Phone: _____ Email:_____

Cancellation and No-Show Policy

Thank you for choosing Treehouse Pediatric Therapy, LLC (Wee Talk, LLC/ Wee CommunicATE LLC/ Sensational Play LLC/ Sensory Play LLC, and OT4ACHILD LLC). We recognize that from time to time situations arise and plans need to be changed due to situations beyond your control. This is a regularly scheduled appointment so please plan ahead to ensure that your child's therapy time is blocked off each week.

ATTENDANCE

Parents must keep 75% of scheduled therapy visits per month. Clients who drop below this attendance percentage for two consecutive months, risk having the frequency of therapy services reduced and/or being discharged from therapy services. This decision is at the therapist's discretion.

Guardian/Parent Signature_____

LATE ARRIVAL/EARLY DEPARTURE

Therapy sessions last 55 minutes unless predetermined by the therapist. If your child arrives late to therapy or needs to depart early from therapy, the scheduled therapy rate will be charged in full.

Guardian/Parent Signature_____

NO SHOW

If you need to cancel your appointment please notify your therapist/s immediately. If you do not notify your therapist/s via phone or email of a cancellation **24 hours prior** to your scheduled appointment, it will be considered a "no-show". If a "no-show" occurs, you will be billed $50 for a missed clinic and teletherapy session and $65 per hour for a missed off- site session. We ask that you please notify your therapist as soon as you know that your child is ill or that there is a family emergency. Therapy services can be terminated at the discretion of the therapist. Thank You.

Guardian/Parent Signature_____

CANCELLATION DUE TO ILLNESS

It is important that the parent/guardian and therapist be respectful of any health concerns as we have many medically fragile children attending Treehouse. Children with diarrhea, vomiting, contagious diseases, and/or temperatures should not be seen for therapy. Please notify your therapist as soon as possible if your child exhibits any of these symptoms and will not be attending therapy. *Your child should be symptom free for 24 hours before resuming therapy*.

Guardian/Parent Signature_____

INCLEMENT WEATHER/HOLIDAYS

In the event of inclement weather, please check our website and facebook for the most current updates regarding closings. We will not follow any particular school system's decision regarding opening and closing. Holidays will be posted in Treehouse, on the website, and facebook. Please let your individual therapist know if your family will be missing therapy due to a holiday and/or vacation. Please follow our regular cancellation policy for inclement weather and holidays unless noted by Treehouse Pediatric Therapy, LLC or your individual therapist.

Guardian/Parent Signature_____

I understand and agree with the cancellation and no-show policy as written.

_____

Parent Signature **Date**

Treehouse Pediatric Therapy Payment Policy

PAYMENT

Payment is due in full on the date the service is provided. Initial _____ Payment can be received via check, cash, or credit card. Credit card payment will include a convenience fee. Please ask for the convenience fee rate if needed.

INSURANCE

We do not accept insurance as payment for services. However, after payment has been made to Sensational Play LLC/ Sensory Play LLC, or Treehouse Pediatric Therapy, LLC and after services have been rendered, then we can provide you with an itemized monthly receipt for you to submit to your insurance company. Since insurance companies vary widely in their reimbursement for out-of-network providers, we in no way guarantee that you will receive any reimbursement. If the insurance company requires supporting documentation from us, we will be happy to provide that to you. We recommend that you talk with your insurance company prior to making a commitment to your therapy session here so that you have an idea of what your final out of pocket expense will be.

OUTSTANDING BALANCES

Invoices for outstanding balances on accounts greater than 30 days will be charged an additional $25 late fee per month. Accounts with balances after 60 days will be charged an additional 25% of the current outstanding balance to cover collection agency fees. The guardian/parent will be responsible for any additional costs associated with a collection agency. Therapy will be placed on hold after 60 days of non-payment. The child will be placed on the waitlist until payment is received.

Fees/Therapy Rates (as of October 1, 2024)

- 55 minutes OT/ST/PT = $105.00, 45 minutes = $90.00, 25 minutes=$65.00
- 55 minute Social pairing = $75.00
- 55 minute Myofunctional therapy = $120.00
- 55 minute consultation = $165.00, 55 minute
- Myofunctional consultation = $200.00
- 55 minute multi-disciplinary therapy = $80.00 per provider
- 55 minute Augmentative/Alternative Communication Therapy = $110.00
- Therapy/meetings provided at a location other than Treehouse clinic will be at the treatment rate plus an additional $10
- Consultation/Phone calls = $65.00 for 30 minutes or less, $105.00 for any amount of time between 30-60 minutes
- Evaluation and report = $450.00

I understand that my credit card will be charged a convenience fee in addition to the therapy rate as listed below. This is subject to change.

Session	$ fee	Total charged
105 therapy	3.75	108.75
165 consult	5.00	170.00
450 eval	15.00	465.00

I agree with the rates, payment policy, and outstanding balance policy as listed above.

Parent Signature_____ **Date**_____

Treehouse Pediatric Therapy
12201 Gayton Road
Henrico, VA 23238
(804) 794- PEDS
(804) 794-7399 FAX
treehousepediatrictherapy@gmail.com

CREDIT CARD AUTHORIZATION FORM

I,_____, give permission to Treehouse Pediatric Therapy to charge my credit card weekly for treatment sessions . My card details will be stored in my profile.

_____
Cardholder email

Card Information

Card type (VISA, MC, etc.) _____

Cardholder (name on card) _____

Card number _____

Expiration date(MM/YYYY)_____

CVC _____

Billing Address with zip code _____

_____

_____

_____ _____
Customer signature Date

Release of Information Form

Client's Name: _____

Client's DOB: _____

Parent's Name:_____

Parent's Contact number: _____

Person/Agency: _____

Contact information: _____

_____

_____

I, _____, give permission for Treehouse Pediatric Therapy to communicate with _____ regarding my child's therapy progress and needs until _____.

Parent/Guardian's signature: _____

Date:_____

Standard Photo Release

In an attempt to develop and maintain a business, we will have a website and print published material which can include photographs and videos of patient and/or patient's family while attending therapy sessions. Inclusion in the website, social media, and printed material is strictly voluntary and is not paid for, endorsed, or compensated in any way. To enable us to include your child/dependent in our website, social media or printed material, we need your signature. Thank you in advance for your assistance.

I _____ (print name), being the parent or guardian of _____ (print patient's name) do hereby give full permission to Wee Talk LLC, Wee CommunicATE LLC, Sensational Play LLC, Sensory Play LLC and OT4ACHILD LLC and Treehouse Pediatric Therapy LLC and any business associated with the aforementioned businesses, to use photographs or videos and/or written information of my child/dependent on the website, social media, and in printed materials.

I waive any right I have to inspect and approve the finished product or copy that may be used.

I affirm that I am over the age of 18 years, and I am the parent/guardian of the above-mentioned patient.

_____
Signature of Parent or Legal Guardian

_____
Date