MARIAN HOPE

CENTER FOR CHILDREN'S THERAPY

14820 E. 42nd Street, Independence, MO 64055 • p 816.695.1255 • f 816.478.7762 • www.marianhope.org

PRIOR TO YOUR CHILD ATTENDING THE MARIAN HOPE CENTER, ALL COMPLETED FORMS MUST BE RETURNED.

2019 SUMMER ENROLLMENT FORM – New Families

Child's Name_____ **Birth date**_____

Class (day & time)_____

Date of Enrollment_____ **Enrollment Period:** ☐ Fall/Spring ☐ Summer

Parent(s) Name(s)_____

Address_____ City_____ State_____ Zip_____

Home Phone_____

Mom: Work Phone_____ ***Dad:*** Work Phone_____

Cell Phone_____ Cell Phone_____

Email_____ Email_____

Emergency Contact(s) (other than parents):

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Others allowed to pick up your child: ☐ *Same as emergency contacts*

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Child's Physician:

Name_____ Phone_____

Address_____ City_____ State_____ Zip_____

Diagnosis_____

Special Precautions/Allergies/Medicines_____

_____

_____

Concerns to be addressed_____

_____

_____

Child's Name_____ **Birth date**_____

Enrollment Fee for 2019 SUMMER Session (*June 3 to Aug 9*)

The enrollment fee covers cost of materials, snacks, supplies, etc. for the Marian Hope Center. The enrollment fee does ***not*** include the cost of therapy and cannot be billed to insurance companies, Medicaid, First Steps, or the KCRO Autism Project. It must be paid by the families. In order to reserve your child's place in one of our therapy classes, **please pay the enrollment fee no later than *June 1***. If you have questions, please contact Heather Ruoff at 816-695-1255.

- ☐ 3-hour class enrollment fee = $100
- ☐ 2.5-hour class enrollment fee = $ 85
- ☐ 2-hour class enrollment fee = $ 75
- ☐ 1.5-hour class enrollment fee = $ 50
- ☐ 1-hour class enrollment fee = $ 35

Please select how you would like to pay the enrollment fee:

Check one:

☐ Cash ☐ Check ☐ Credit Card

Check one: ☐ Visa ☐ Mastercard
☐ American Express ☐ Discover

Card #: _____ Exp. Date: _____

Billing Policy for 2019 SUMMER Session (*June 3 to Aug 9*)

Thank you for choosing Marian Hope Center as the therapy provider for your child. We are committed to providing quality services and implementing individually appropriate assessment and intervention plans. Please understand that payment for the services provided is an integral part of the process and ensures Marian Hope Center can continue to be of service to you and others.

Billing Policy:

1. You, the client's parent/guardian/guarantor are responsible for payment for all services provided. Any amounts eligible for payment by insurance or state-based programs will be billed to your insurance/programs, but any amounts not paid by your insurance/programs will be invoiced to you and is your responsibility for payment.
2. Therapy services will be billed according to the rate schedule below.
3. You will be invoiced at the end of each month for the services provided during the month.
4. Payment is expected promptly upon receipt of the monthly invoice. A service fee of 10% will be applied to any accounts that are 30 days past due.
5. We accept cash, checks or credit card (MasterCard, Visa, American Express and Discover).
6. If needed, Marian Hope Center will work with you to arrange a reasonable payment plan to help you manage your payments for the services provided.
7. Any unpaid balances may be subject to collections.

Insurance/Medicaid Policy:

1. We are in-network providers with Blue Cross Blue Shield, UHC & Tricare-UHC. Once it is determined that your child has speech and/or occupational therapy coverage, we will submit claims to in-network companies. It is your responsibility to pay the member responsibility portion that your plan does not cover (deductible, co-pay, co-insurance and any additional fees).
2. If Marian Hope Center is out of network with your insurance carrier, we will check the benefits with your insurance carrier and determine coverage for your child's diagnosis as an out of network provider. If you choose, we will file insurance claims as an out of network provider. It is your responsibility to pay the member responsibility portion that your out of network plan does not cover (deductibles, co-pay, coinsurance and any additional fees).
3. Regardless of any benefits quoted to Marian Hope Center by your insurance carrier, there is no guarantee of payment. You, the client's parent/guardian/guarantor, are ultimately responsible for payment for services provided.
4. We are only a straight-Medicaid provider. Since we are not a provider with any of the insurances that are associated with MO Health Net, we cannot accept MO Health Net insurance. If you have this funding source and choose to have services provided by Marian Hope Center, all services will be billed to you, the parent/guardian/guarantor.
5. Clients and their parent/guardian/guarantor are responsible for understanding the percentage of coverage allowed by their insurance policy and for understanding the deductible and coinsurance/co-pay applicable to their specific insurance policy.
6. Clients and their parent/guardian/guarantor are responsible to track visits used for therapy for the policy year and know when the allowable number of visits have been exhausted for the policy year. It is not the responsibility of Marian Hope Center to notify clients and their parent/guardian/guarantor when insurance allowable visits have been exhausted for the policy year. If the maximum number of insurance allowable visits is exceeded for a policy year, additional therapy sessions provided will be billed to the client's parent/guardian/guarantor at the private pay rates explained below.

Class Setting Therapy Rate Schedule

Our rates for individual therapy provided in a class setting are determined by the length of the class in which the client is enrolled.

1. 5-hour therapeutic class - both speech and occupational therapies provided
    - $120/hour/ therapy
        - If the client has insurance coverage and diagnosis for both therapies, claims for both therapies will be billed to insurance.
        - If the client has a diagnosis and insurance coverage for only one therapy, then insurance will be billed for the covered therapy. You will also be billed at a discounted rate of $72.50/session for class time.
        - If there is no insurance coverage or diagnosis for the client, you will be billed for the class at a discounted rate of $145.00/session.

2. 4-hour therapeutic class - both speech and occupational therapies provided
    - $120/hour/ therapy
        - If the client has insurance coverage and diagnosis for both therapies, claims for both therapies will be billed to insurance.
        - If the client has a diagnosis and insurance coverage for only one therapy, then insurance will be billed for the covered therapy. You will also be billed at a discounted rate of $62.50/session for class time.
        - If there is no insurance coverage or diagnosis for the client, you will be billed for the class at a discounted rate of $125.00/session.
3. 3-hour therapeutic class – both speech and occupational therapies provided
    - $120/hour/ therapy
        - If the client has insurance coverage and diagnosis for both therapies, claims for both therapies will be billed to insurance.
        - If the client has a diagnosis and insurance coverage for only one therapy, then insurance will be billed for the covered therapy. You will also be billed at a discounted rate of $50.00/session for class time.
        - If there is no insurance coverage or diagnosis for the client, you will be billed for the class at the discounted rate of $100.00/session.
4. 2.5-hour therapeutic class - both speech and occupational therapies provided
    - $120/hour/ therapy
        - If the client has insurance coverage and diagnosis for both therapies, claims for both therapies will be billed to insurance.
        - If the client has a diagnosis and insurance coverage for only one therapy, then insurance will be billed for the covered therapy. You will also be billed at a discounted rate of $45.00/session for class time.
        - If there is no insurance coverage or diagnosis for the client, you will be billed for the class at a discounted rate of $90.00/session.
5. 2-hour therapeutic class - both speech and occupational therapies provided
    - $120/hour/ therapy
        - If the client has insurance coverage and diagnosis for both therapies, claims for both therapies will be billed to insurance.
        - If the client has a diagnosis and insurance coverage for only one therapy, then insurance will be billed for the covered therapy. You will also be billed at a discounted rate of $40.00/session for class time.
        - If there is no insurance coverage or diagnosis for the client, you will be billed for the class at a discounted rate of $80.00/session.
6. 1-hour therapeutic class – either speech or occupational therapies provided
    - $120/hour/ therapy
        - If the client has insurance coverage and diagnosis for a therapy, claims for that therapy will be billed to insurance.
        - If there is no insurance coverage or diagnosis for the client, you will be billed for the class at a discounted rate of $50.00/session.

Individual Therapy Rate Schedule

Individual therapy services are provided at Marian Hope Center or through the Outreach Program within the community setting or in the client's home.

1. Assessments include the evaluation and report writing at an hourly rate of $120.00/hour with a two-hour minimum charge. If you do not have insurance or state program coverage for this service, you will be billed at a discounted rate of $70.00/hour with a two-hour minimum charge.

2. Individual Therapy Sessions
    - If the client has insurance coverage and diagnosis for a specific therapy, claims for the covered therapy will be billed to insurance.
    - If there is no insurance coverage or diagnosis for the client, you will be billed for the therapy session according to the following discounted rate schedule:
        - 15 min = $20.00
        - 30 min = $40.00
        - 45 min = $60.00
        - 1 hour = $70.00

Additional Therapy Services Rate Schedule

1. Reading Services
    - Reading classes are not billable to insurance or state programs.
    - You will be billed at month end for sessions attended.
    - Sessions are billed at $50/hour.
    - Evaluations and reports are billed at $50.00/hour with a minimum time of 1 hour.
2. Para Services
    - Para services are not billable to insurance or state programs.
    - You will be billed at month end for sessions attended.
    - Sessions are billed at $7.50/hour for para time within a class setting.
    - Sessions are billed at $15.00/hour for individual para time with a client.
3. IEP Meetings
    - If the client is enrolled at the Marian Hope Center, one therapist will attend one IEP meeting per calendar year at the parent's request. If the meeting time exceeds 90 minutes or if the therapist is asked to attend additional meetings, the client's parent/guardian/guarantor will be billed for this additional time at $50/hour. Mileage for meetings held outside of the Kansas City metro area will also be billed to the client's parent/guardian/guarantor at the then current IRS mileage reimbursement rate for round-trip mileage to/from Marian Hope Center.
4. Phone/Email Consultations
    - These services are any additional consultation time outside of normal consultation during a therapy session requested by the parent/guardian/guarantor to guide the parent/guardian/guarantor in the application of therapeutic strategies or recommendations developed by the licensed therapist.
    - Phone/Email consultations are not billable to insurance or state programs.
    - You will be billed for the consultation time according to the following rate schedule:
        - 15 min = $15.00
        - 30 min = $30.00
        - 45 min = $45.00
        - 1 hour = $55.00
5. Class Enrollment Fees
   Class enrollment fees are assessed by semester at Marian Hope Center and are identified in the class enrollment paperwork. These fees are due at the time of enrollment in the class.

Marian Hope Center is contracted as a provider through the MO First Steps and KCRO Autism Project programs. If your child has been approved for one of these programs, Marian Hope Center will bill for services based on its contracted rates and attendance of your child for therapy sessions.

I have read the above three (3) pages of Marian Hope Center's Billing/Insurance/Rate Schedule Policy and agree to the terms set forth in this policy by Marian Hope Center for Children's Therapy. I understand that I am responsible for knowing and understanding all of the information contained in this billing policy. I acknowledge that I am the parent/guardian/guarantor for the client identified below, and I acknowledge that I am responsible for payment for all services provided to the client by Marian Hope Center.

_____ _____

Signature of Parent or Responsible Party **Date**

Child's Name_____ **Birth date**_____

Child's Name_____ **Birth date**_____

☐ First Steps - Service Coordinator: _____

☐ KCRO/Autism Project - Service Coordinator: _____

☐ Insurance *(copy of card is required)*

Is your child the primary Insurance Policy Holder? ☐ Yes ☐ No*

*If you answered No, please supply the following information regarding the policy holder (to be used for insurance claim forms)

Policy Holder Name: _____

Address *(if different from child):* _____

Phone Number *(if different from child)*: _____

Policy Holder Date of Birth: _____

Policy Holder Employer: _____

☐ Medicaid *(copy of card and a doctor's script is required)*

☐ Private Pay

☐ Peer Model *(my child will not receive direct therapy services during class)*

Child's Name_____ **Birth date**_____

Consent for Care and Treatment

As the child's parent or legal guardian, I hereby consent to necessary evaluation, procedures and/or treatments prescribed by my child's therapist as is necessary in her judgment. I understand that my child is under the care and supervision of my therapist. The Marian Hope Center is a teaching facility. There will be students, volunteers, and clinical interns that may be observing or supporting the therapists in treatment areas. I authorize this as a part of my child's treatment at the Marian Hope Center.

_____

Print name

_____

Signature of legal representative of child Date

Cancellations

Please note: ***Marian Hope Center requires 24-hour notice if a child will not be attending a scheduled appointment.*** A therapist may be contacted by phone or email OR Heather Ruoff may be contacted at 816-695-1255 or hruoff@marianhope.org. If your child is absent from a class and 24- hour notification has NOT been received a $40 charge will be billed to the parents/caregivers for the missed session, regardless of payment source *(KCRC, insurance, etc.)*.

In the event that it is necessary for the Marian Hope Center to cancel a therapy class, families will be notified via email and it will be posted on the Marian Hope Center website and Facebook page.

Acknowledgement of Policies

Please review the above Cancellation Policy, the HIPPA Confidentiality Policy, and the Parent Handbook before checking each of the following boxes and signing below.

- ☐ I have read and understand the above cancellation policy put forth by the Marian Hope Center.
- ☐ I have read and understand the attached HIPPA confidentiality policy. I will not disclose any information or ask questions to staff regarding other children and their families who participate in the class.
- ☐ I have read and understand the policies explained in the 2018-2019 Marian Hope Center Parent Handbook.

_____ _____

Signature of legal representative of child Date

Child's Name_____ **Birth date**_____

Consent for Parent Observation

I understand that other parents may observe my child in therapy as the parents observe their child in therapy.

☐ I consent to the presence of other parents in the same treatment area with my child as the parents observe their child in therapy.

☐ I do not consent to have other parents in the same treatment area as my child.

_____ _____
Signature of legal representative of child Date

Statement of Confidentiality

The undersigned hereby acknowledges his/her responsibility under federal applicable law to keep confidential any information regarding Marian Hope Center clients, as well as all confidential information of the Marian Hope Center. The undersigned agrees under penalty of law, not to reveal to any person or persons except authorized clinical staff and associated personnel any specific information regarding any client.

_____ _____
Signature of legal representative of child Date

_____ _____
Witness Date

Consent for Photographs & Videos

I hereby authorize the Marian Hope Center to photograph or video my child for the purposes of treatment, education, and professional reasons. I also understand that my child may be in group pictures or video that may also be reviewed by others outside the Marian Hope Center.

Pictures of the children that attend the Marian Hope Center may be used for publications, advertising, website, Marian Hope Center Facebook page, and/or financial proposals. This authorization is valid for the duration of my child's therapy from the date signed below. I understand that I may revoke this authorization at any time, but will not hold the therapist and/or staff of the Marian Hope Center responsible for pictures or video already taken of my child.

_____ _____
Signature of legal representative of child Date

Child's Name_____ **Birth date**_____

Nutrition Program

The dietary and biological information provided by the staff at the Marian Hope Center for Children's Therapy is not intended to diagnose, treat, or cure any illness or to provide medical advice. We are not medical doctors and we do not prescribe medication. We highly value the connection between nutrition and learning which is why we have a Registered Dietitian on staff to recommend dietary interventions and nutrition supplements.

Our dietitian is ready to serve you through diet, supplement, and lifestyle modification recommendations. This can be done through private pay appointments, grocery store tours, and our free monthly nutrition support group. If you have any questions about the relationship between nutrition, supplements, and your child's health, we recommend that you make an appointment to see our Registered Dietitian. The information provided is based on well-documented research. Extensive research has been done regarding bio-chemical interventions for children with special needs. Our nutrition standards of practice are based on literature and research by a variety of medical doctors, chiropractors, naturopathic physicians, biochemists, dietitians, and other professional researchers. You are encouraged to make your child's health care decisions based on your own research and the advice of a qualified health care professional.

If you are interested in more information regarding nutrition and children with special needs please contact us to make an appointment with our dietitian.

I have read and understand the above statement.

_____ _____

Signature of legal representative of child Date

Child's Name_____ **Birth date**_____

Nutrition Checklist

Please check the following statements that apply to the child you are enrolling.

- ☐ My child does NOT have bowel movements daily.
- ☐ My child has taken more than 3 rounds of antibiotics since birth.
- ☐ My child has a history of or current skin rashes/eczema.
- ☐ My child craves dairy and/or gluten *(wheat flour)* containing foods.
- ☐ My child complains of an upset stomach frequently.
- ☐ My child behaves differently or complains of physical symptoms after eating certain foods.
- ☐ My child is NOT taking a multivitamin, probiotic, and cod liver/fish oil.
- ☐ My child does not eat foods from all the food groups or is very selective of foods.
- ☐ My child demonstrates aggressive behavior and is not on a dairy-free diet.
- ☐ I feel my child's nutrition could be improved.

If you checked more than 3 boxes, nutrition could be playing a role in your child's current developmental status and a nutrition consult should be considered.

Child's Name_____ **Birth date**_____

Fundraising Responsibility

As a non-profit organization, the Marian Hope Center relies heavily on fundraising to maintain the highest quality of services in a safe and comfortable atmosphere. We expect your family to support our organization in any manner available to you. We schedule four major annual fundraisers in addition to smaller events. Donations to the Marian Hope Center are tax-deductible. Please let us know what type of support we can expect from your family this year:

- ☐ Donation of needed items to the Marian Hope Center
- ☐ Volunteer time at the Marian Hope Center or at a Marian Hope Center fundraising event
- ☐ Monetary donation to the Marian Hope Center in the amount of $_____

We appreciate your assistance and commitment to the Marian Hope Center. Our organization would not be able to realize our mission without the support of our families. A staff member from the Marian Hope Center will contact you regarding your fundraising responsibility.

Name: _____

Please contact me via: ☐ Phone: _____

☐ Email: _____

MARIAN HOPE CENTER FOR CHILDREN'S THERAPY
PATIENT PRIVACY RIGHTS

Policy

It is the policy of the Marian Hope Center to implement the following policies and procedures that will ensure patient privacy rights in accordance with the Privacy Regulations promulgated under HIPAA:

1. **Availability of Marian Hope Center for Children's Therapy's Privacy Notice.** The patient has the right to receive our privacy notice in a timely manner. Upon request, the patient may at any time receive a paper copy of our privacy notice, even if he or she earlier agreed to receive the notice electronically. We must also post our privacy notice in a prominent location.

2. **Requesting restrictions on certain uses and disclosures.** The patient has the right to object to, and ask for restrictions on, how his or her health information is used or to whom the information is disclosed, even if the restriction affects the patient's treatment or our payment or health care operation activities. The patient may want to limit the health information that is included in patient directories, or provided to family or friends involved in his or her care or payment of medical bills. The patient may also want to limit the health information provided to authorities involved with disaster relief efforts. However, we are not required to agree in all circumstances to the patient's requested restriction.

3. **Receiving confidential communication of health information.** The patient has the right to ask that we communicate his or her health information to them in different ways or places. For example, the patient may wish to receive information about their health status in a special, private room or through a written letter sent to a private address. We must accommodate requests that are reasonable in terms of administrative burden. We may not require the patient to give a reason for the request.

4. **Access, inspection and copying of health information**. With a few exceptions, patients have the right to inspect and obtain a copy of their health information. However, this right does not apply to psychotherapy notes or information gathered for judicial proceedings, for example. In addition, we may charge the patient a reasonable fee for copies of their health information.

5. **Requesting amendments or corrections to health information**. If the patient believes their health information is incomplete or incorrect, they may ask us to correct the information. The patient may be asked to make such requests in writing and to give a reason as to why his or her health information should be changed. However, if we did not create the health information that the patient believes is incorrect, or if we disagree with the patient and believe his or her health information is correct, we may deny the request. We must act on the request within 60 days after we receive it, unless we inform the patient of our need for a one-time 30-day extension.

6. **Receiving an accounting of disclosures of health information**. In some limited instances, the patient has the right to ask for a list of the disclosures of their health information that we have made during the previous six years. This list must include the date of each disclosure, who received the disclosed health information, a brief description of the health information disclosed, and why the disclosure was made. We must furnish the patient with a list within 60 days of the request, unless we inform the patient of our need for a one-time 30-day extension, and we may not charge the patient for the list, unless the patient requests such list more than once in a 12 month period. In addition, we will not include in the list disclosures made to the patient, or for purposes of treatment, payment, health care operations, our directory, national security, law enforcement/corrections, and certain health oversight activities.

7. **Complaints**. Patients have the right to file a complaint with us and with the federal Department of Health and Human Services if they believe their privacy rights have been violated. We will not retaliate against the patient for filing such a complaint. To file a complaint with either entity, the patient should contact Susan Stickney, the Privacy Officer, who will provide the patient with the necessary assistance and paperwork.

Procedures

1. Should the law regarding patient privacy rights under HIPAA change, we will update our organization's policies and procedures regarding those rights, if applicable.

2. All new staff of the Marian Hope Center shall receive a copy of this document at employee orientation and be directed at orientation as to how to access more detailed privacy policy and procedure documents.

3. All current staff of the Marian Hope Center shall receive a copy of this document as part of our HIPAA compliance training session, and upon request.

Child's Name: _____ Birth date: _____

Parent Concerns

Speech/Language Concerns

Occupational Therapy Concerns *(sensory, feeding, fine motor, etc)*

Academic Concerns

Social/Emotional/Behavioral Concerns *(attention, focus, etc)*

Other Concerns

30 Question Predictive Checklist

To Reveal Potential Vision Problems

NAME_____ **GRADE**_____ **AGE**_____

DATE_____ **COMPLETED BY** (SELF / TEACHER / PARENT)_____

After you consider each question, mark the column that applies to the person you are assessing.

0 = Never 1 = Seldom 2 = Occasional 3 = Frequently 4 = Always

Blur when looking at near	0	1	2	3	4	
Double vision, doubled or overlapping words on page (See example on other side.)	0	1	2	3	4	
Headaches while or after doing near vision work	0	1	2	3	4	
Words appear to run together when reading	0	1	2	3	4	
Burning, itching, or watery eyes	0	1	2	3	4	
Falls asleep while reading	0	1	2	3	4	
Seeing and visual work is worse at the end of the day	0	1	2	3	4	
Skips or repeats lines while reading	0	1	2	3	4	
Dizziness or nausea when doing near work	0	1	2	3	4	
Head tilts or one eye is closed or covered while reading	0	1	2	3	4	
Difficulty copying from the chalkboard	0	1	2	3	4	
Avoids doing near vision work such as reading	0	1	2	3	4	
Omits (drops out) small words while reading	0	1	2	3	4	
Writes up or down hill	0	1	2	3	4	
Misaligns digits or columns of numbers	0	1	2	3	4	
Reading comprehension low, or decliners as day wears on	0	1	2	3	4	
Poor, inconsistent performance sports	0	1	2	3	4	
Holds books too close, leans too close to computer screen	0	1	2	3	4	
Trouble keeping attention centered on reading	0	1	2	3	4	
Difficulty completing assignments on time	0	1	2	3	4	
First response is “I can’t” before trying	0	1	2	3	4	
Avoids sports and games	0	1	2	3	4	
Poor hand/eye coordination, such as poor handwriting	0	1	2	3	4	
Does not judge distances accurately	0	1	2	3	4	
Clumsy, accident prone, knocks things over	0	1	2	3	4	
Does not use or plan his/her time well	0	1	2	3	4	
Does not count or make change well	0	1	2	3	4	
Loses belongings and things	0	1	2	3	4	
Car or motion sickness	0	1	2	3	4	
Forgetful, poor memory	0	1	2	3	4	
20-24 points = Suspect 25 points or more = Refer for care				**TOTAL SCORE**		

This predictive checklist was developed by optometrists and educators for the College of Vision Development (www.covd.org). Please call John Metzger, OD at 913-469-8686 with questions or to schedule a private consultation.

Revised 5/2/2019