



Treatment and Payment Policy

Thank you for choosing Cornerstone Therapy Associates (Cornerstone) for your occupational therapy services. We believe that there should be a clear understanding between the therapist and patient as to their rights and responsibilities. Please review and sign the following Treatment and Payment Policy prior to beginning services. If you have questions, please do not hesitate to ask for clarification.

Treatment

You will have the opportunity to discuss the benefits of the proposed procedures and therapeutic courses of treatment with the therapist to your satisfaction.

You have the right to consent or refuse any proposed therapeutic course of treatment.

Subject to the foregoing, the therapist may administer any therapeutic procedure deemed advisable to your care and treatment.

Services

Cornerstone Therapy Associates provides detailed performance and sensory evaluations as part of our service. A typical evaluation can range between three to six hours of direct assessment/observation and consultations from which reports are generated, some of which could include:

- Interview with Family and Observation 1 – 1.5 hours
- Sensory/Performance Assessment Profile 1 – 1.5 hours
- Written Report with Recommendations 1 – 1.5 hours
- Review/Consultation with Results 1 – 1.5 hours

It is our policy that **OT services are not billed through insurance**. The hourly cost for both evaluations and regular OT sessions is \$100 an hour.

Your insurance provider may offer out-of-network benefits, which means they might reimburse a portion of the services provided through Cornerstone. This depends on your insurance provider as well as your insurance plan, so you should call to confirm with your insurance prior to the start of treatment.

Cancellations or Missed Appointments

Cancellations or rescheduling requests with less than 24 hours' notice may result in a cancellation fee of \$50 charged to your account. We do consider exceptions for unavoidable emergencies on a case-by-case basis.

Frequent cancellations and/or missed appointments (no show) may result in a reduction of scheduled sessions.

Payments and Billing

Cornerstone is a private facility which relies solely on income from patients. In order to provide the best possible therapy care at the lowest possible cost. You will be billed at the end of each month for all OT services provided within that month. For example, OT sessions provided in the month of January, will be billed within the first 10 days of February. You are responsible for paying the bill in full unless special arrangements have

been made in advance. A Late Fee of \$10 per week will be applied on balances that are still unpaid after 14 days of receiving your invoice. There is a fee of \$20 for returned checks. Delinquent accounts may be turned over to a collection agency at which time you agree to be responsible for collection charges and all associated legal fees in addition to the amount owed. We will accept checks, cash, or electronic payment for therapy services.

I have read, understand and agree to the Treatment and Payment Policy as described above and understand that Cornerstone Therapy Associates may refuse treatment if I do not remain current in payments for therapy services.

_____	_____	_____
Patient or Guarantor Name (print)	Patient or Guarantor Signature	Date

_____	_____	_____
Minor Patient's Name	Relationship to Guarantor	Date

The terms "you and your" in this policy are the patient and the patient's guarantor, if applicable. A guarantor is the individual who accepts financial responsibility for services rendered to a minor, incapacitated or otherwise legally dependent patient. The guarantor may be a family member or a non-family member with legal authority to act on the patient's behalf, including the authority to consent to services. By signing this form as guarantor on behalf of a minor, incapacitated or otherwise legally dependent person, you represent to Cornerstone that you have such authority.

Please initial the following:

____ I (patient/guarantor) hereby acknowledge that I have been provided with a copy of the Cornerstone Therapy Associates Treatment and Payment Policy.

For office use only:

____ A copy of the Cornerstone Therapy Associates Treatment and Payment Policy was made available to the patient/guarantor and the patient/guarantor refused to initial the acknowledgement.