APD THERAPY

ATTENDANCE& FINANCIAL AGREEMENT

Below is some important information to consider for your child's therapy appointments:

1. Please call your insurance company to verify your out-of-network benefits and understand your financial responsibility prior to testing. ***We are out-of-network for all insurance companies***. You may need the following information:
   - NPI # - 1548505811
   - Tax ID # - 46-1353424
   - CPT Code – 92507
   - Diagnosis Code – H93.25 (Central Auditory Processing Disorder)
2. Evaluations from other facilities will be accepted as long as they have been completed within 3 months of the therapy start date. If the evaluation is not completed at Little Listeners, a 1-hour consultation with the parent(s) or guardian will be required prior to selecting therapy dates to review the results and recommendations and to develop a plan of care.
   The consultation fee is $150.The report will need to be forwarded to us prior to the consultation session either by faxing to 770-573-6399 or emailing a scanned copy to drreeves@littlelistenersclinic.com.
3. Therapy is typically scheduled for a minimum of 15-20 sessions. The final two sessions will include a reassessment at which time the need for more sessions will be evaluated and a progress note will be provided.
4. Therapy will be administered by a GA licensed Audiology Assistant under the GA Rule 609-6-02 licensing guidelines and the individual licenses authorized by the GA Secretary of State Licensing Board for Speech Pathology and Audiology. Make-up sessions, scheduling conflicts, and re-evaluations may be scheduled with the Audiologist randomly to accommodate client schedule requests.
5. Fees for therapy are as follows:
   - $80.00 per 30-minute session
   - $65.00 each if pre-paid for 5 or more sessions at a time
   - $910.00 total for 15 sessions or $1235 for 20 sessions if all pre-paid at once (additional $65 discount = one free session)
6. Please be on time for each therapy appointment. ***Rates will not be prorated for partial sessions if you are late***.
7. *Please carefully review the schedule given to you at the start of your sessions and notate any anomalies for clinic closings. We will do our best to send out reminders if our clinic is closed expectedly or unexpectedly, but it's your responsibility to reconcile your personal calendar with our appointments for your child as outlined at the beginning of their sessions. We can print out a new schedule at any time if changes occur.*
8. Please give 24 hours notice if an appointment needs to be cancelled or rescheduled. ***After the first occurrence, a $25 fee may be charged for each missed therapy visit***. If 3 or more therapy sessions are cancelled without advanced notice, your child may be discharged from therapy to open up spots for other children that are wait listed.
9. If your child misses school for illness or experiences sudden signs of illness, he/she should not attend therapy. Last minute cancellations due to illness are excused and will not count towards the cancellation policy.
10. We follow the Forsyth County school system policy for inclement weather. If Forsyth schools are closed, our clinic will be closed as well. Cancellations due to inclement weather will not count towards the cancellation policy. Every effort will be made to confirm inclement weather closings by email, but when in doubt, please follow the news announcements regarding school closings.
11. If your child is permitted to stay at home alone, they may attend their appointment without your supervision, but please be available for the last 5 minutes of their appointment time to discuss their progress and home assignments.
12. Parents are not permitted leave the premises or be in the therapy room during therapy sessions unless specifically requested by or arranged with the therapist. Please limit cell phone use in the waiting room so as to not disturb other families.

By signing below, you are acknowledging that you have read and understand the rules for therapy, financial agreements and the attendance policy. Please don't hesitate to call or email if you have any questions. *Email is always best.*

______________________________	____________________________________	____________________
Print Name of Patient	Signature of Responsible Party	Date