7528 Gardner Park Drive, Gainesville, VA 20155 571-248-1784

Client Information and Contract Agreement

Client Name: ________________________________ DOB: _________ Date: __________

Social Security Number: _________________________ Sex: _______

Address: ____

City: ________________________________ State: __________ Zip Code: ___________

Home Phone: __________________________ Work Phone: ________________________

Cell Phone: ____________________________ Email: ______________________________

Emergency Contact

Name: ____

Cell phone: _________________________ Home Phone: ________________________
Work Phone: ________________________

Email: ____

Relationship: ____

Parent / Guardian Information: Required if the patient is under 18 years of age

Parent Name: ____

DOB: _________________________ Social Security Number: __________________

Custody Status: _____________ Legal: _______ Physical: _______

Address: ____

City: State: Zip: ____

Primary Insurance Information (Casper Minds LLC. will need a copy of both sides of the insurance card)

Relationship to insured:	Employer:	
Group Number:		
Member ID Number		
Effective Dates:	To:	From:

Insured's Information (if not self)

Relationship to insured:		
Last Name:	First Name:	
Date of Birth:	Social Security Number:	
Marital Status:	Sex	
Address:		
City:	State:	Zip Code:

Secondary Insurance Information

(If Applicable, Casper Minds LLC will need a copy of both sides of the insurance card) Casper Minds LLC does not bill secondary insurance except as required by law.

Insurance Company:		
Group Number:		
Member ID Number:		
Effective Dates:	To:	From:

Insured's Secondary Information (if not self)

Relationship to insured:	Employer:	
Last Name:	First Name:	
Date of Birth:	Social Security Number:	
Marital Status:	Sex:	
Address:		
City:	State:	Zip Code:

Cancellation and Financial Policies

- Confidentiality is of the utmost importance when working with individuals and family members. You may see individuals at Casper Minds, which you did not expect, please respect their confidentiality as well as their privacy. This can be a difficult time for some families, please remember that. _______ (initial)
- **If you are not able to attend the Group Lesson, 1:1 session Casper Minds LLC will need 24 hour cancellation; otherwise there will be a cancellation fee of $90.00. _____ (initial)**
- Therapy sessions must be canceled for any of the following reasons: _____ (initial)
    1. Vomiting, temperature (100.4 degrees or higher), or diarrhea
    2. Persistent hacking cough with green or yellow phlegm being coughed up
    3. Green or yellow nasal drainage
    4. Rash (unless indicated with a doctor's note that the rash is not contagious)
    5. Lice, pink eye, chicken pox, or other contagious conditions
    6. Therapy sessions will not resume until 24 hours after the last episode of vomiting or a fever.
    7. Child misses school due to illness (unless doctor's note indicates that the child's illness is not contagious and therapy session can resume as scheduled)
- If your child attends school and is sent home due to illness, please contact your therapist as soon as possible. You will be charged for half of the therapy session. _____ (initial)
- Families will not be charged for therapy sessions if your child required an emergency room visit or there was a death in the family. _____ (initial)
- All no-show appointments will be billed at the rate of service. This is necessary due to the therapist's inability to see another child during that time slot. Multiple cancellations and/or "no shows" could result in termination of services. _____ (initial)

- **Insurance**
    1. If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and your understanding of our payment policy. You will be asked to update your personal and insurance information periodically, including providing our office with copies of your insurance card and driver's license. We are required by law to obtain your signature for permission to release information to your insurance carrier. Our failure to obtain these updates could result in criminal and civil penalties and/or expulsion from your insurance plan. Please assist us in complying with your insurance requirements. We will gladly submit fees for your covered medical services to your insurance company, if your provider is considered in network. However, we expect payment of all services rendered within 60 days. **It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days.** It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements. We will, however, assist you to ensure that all plan requirements are met. X_____ (Please initial)

    2. I understand that Casper Minds LLC will file and attempt to collect from my insurance company. I further understand that if the claim is not paid within 60 days that I will be billed for the remaining balance. I agree to waive any insurance company policy rights that would prevent me from being responsible for these unpaid charges. X_____ (Please initial)

    3. If your insurance coverage or your insurance carrier changes and you do not notify Casper Minds LLC within 30 days of that change, Casper Minds LLC reserves the right to NOT issue a refund. I agree to waive any insurance company policy rights that require refund of the aforementioned monies. X_____ (Please initial)

        - Failure to pay your co-pay at the time of service will result in a charge of $50.00 to help cover the additional administrative costs. You will be asked to sign a promissory note for the co-pay amount plus the service fee. X_____ (Please initial)

- We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, not your insurance company.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered. X_____ (Please initial)
    1. 1. I accept financial responsibility for all clinical and administrative services provided by Casper Minds LLC
    2. 2. I authorize the release of any medical, mental health, or other information necessary to process a claim with my insurance carrier.
    3. 3. I authorize payment to Casper Minds LLC for all services rendered. I authorize the use of this signature on all my insurance submissions whether manual or electronic.
    4. 4. In many cases, there is a need for us to exchange information with other parties, such as other treating physicians. If you do NOT wish to give us permission or have any doubts about granting this permission at this point to exchange information with other physicians, please cross out this paragraph. If you cross out this paragraph, we will ask you to sign separate release of information forms when and where appropriate.
    5. 5. If my account goes to a third party for collections, I am responsible for all fees incurred.
    6. 6. I understand that if I have a balance on my account that it needs to be paid before my appointment and that failure to pay the debt may result in me not being seen and a missed appointment fee being added to my account. If you are unsure of your balance you may call Casper Minds LLC.

Payment Options for noninsured services

- The payment for the all servicers can be done in weekly, bi-weekly, due on the 15th and 30th of the month or monthly, the first of the month. Cash and Checks made out to Casper Minds will be accepted. Please choose one payment option and initial the returned check fee:
    - I would like to pay weekly. ___________________ (check here and initial)
    - I would like to pay bi-weekly due on the 15th and 30th of the month. _____________ (check here and initial)
    - I would like to pay once a month on the 1st of each month. __________ (initial)
    - I understand that there will be a $30.00 fee for any returned checks. _______ (initial)

- **If you choose to leave Casper Minds, then I will need a 2 week written notice of your departure**. ________ (initial)
- If you have any concerns or comments, please schedule an appointment with me. It is important to me to hear what you have to say and to discuss your needs, but when your child is here, it is their time. ________ (initial)
- If your child has a food allergy please let me know, as there may be times when there may be snacks provided. ________ (initial)

- VACATIONS/HOLIDAYS: _____ (initial)
  - I may be closed on the following days and will do my best to reschedule our sessions for another day if possible:
    - January – New Year's Day,
    - March/April – Good Friday
    - July - Independence Day
    - September - Labor Day
    - November –Thanksgiving Day
    - December - Christmas Eve, Christmas Day and the day after Christmas

- Observation Policy
  - We welcome parents to observe their children during our camp programs, play/social groups, ABA therapy and Speech and Language sessions at the office. Parents may observe for up to 30 minutes per session and a staff member from Casper Minds LLC must be present. You must have consent from Angela Kralik to extend observations past 30 minutes. Other children may be present during your observation; therefore, Casper Minds LLC must receive parent consent prior to any observation. If you have any questions, please feel free to notify Angela Kralik at your convenience. _____ (initial)

I hereby acknowledge and agree to the billing and cancellation policies.

Parent/Guardian Signature: ______________________________Date: ____________________