MICHELLE FOOSANER, MS PT
Children's Therapy Associates
MfoosanerPT@gmail.com
415-606-9773

Patient Services Acknowledgement and Agreement

Patient Name: _____ Date: _____

This Patient Services Acknowledgement and Informed Consent Agreement ("Agreement") for Physical, Speech, or Occupational Therapy Services ("Services") is entered into on __ _____, 201__, by and between Children's Therapy Associates ("Provider"), and _____ [*Name of Parent or Guardian*] ("Client"), who hereby secure the below-described Services on behalf of and for the benefit of the minor child, _____[*Child's Name*] ("Child").

RECITALS

WHEREAS, Client is entering into this Agreement with Provider, all such services shall be rendered by Michelle Foosaner, physical therapy assistants or subcontractor physical therapists, speech therapists, or occupational therapists;

WHEREAS, Michelle Foosaner and subcontracted therapists are licensed in the State of California, and therapy assistants are authorized to practice under the guidance of same; and

WHEREAS, Client seeks to retain the professional services of a therapist for the treatment of a child or themselves.

NOW, THEREFORE, in consideration of the mutual promises and covenants set forth below, the parties agree as follows:

1. FEES FOR THERAPY SERVICES

All fees pertaining to services provided by Provider shall be due and payable in cash prior to or at the time of service, unless Client and Provider agree in writing that payment is acceptable upon receipt of biweekly or monthly billing statements.

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2. GENERAL CANCELLATION FEES

Any and all changes to or must be made at least forty-eight (48) hours prior to the scheduled visit in order to reschedule the visit or request a refund; any cancellation made without at least forty-eight (48) hours prior notice shall be subject to a cancellation fee of 50% of the estimated bill with any balance remaining in your account being applied to future services. Cancellations made with less than twenty-four (24) hours prior notice shall be billed in full.

In the case of cancellations resulting from illness or injury, any cancellation with less than twenty-four (24) hours prior notice will be rescheduled within a 30-day period as client and provider availability permits.

2. CANCELLATION FEES FOR INTENSIVE PT

Any and all changes to or cancellations of appointments for more than three (>3) hours of services within a seven (7) day time frame must be made at least (2) weeks prior to the scheduled visit(s) in order to reschedule the visit(s) or request a refund; any cancellation made without at least two (2) weeks prior notice shall be subject to a cancellation fee of 50% of the estimated bill with any balance remaining in your account being applied to future services. Cancellations of appointments for more than three (>3) hours of services that are made with less than one (1) week prior notice shall be billed in full.

In the case of cancellations of appointments for more than three (>3) hours of services within a seven (7) day time frame resulting from illness or injury, any cancellation with less than one (1) weeks prior notice will be rescheduled within a 60-day period as client and provider availability permits and will not be eligible for refund.

All cancellation fees shall be immediately due and payable.

3. RIGHT TO REFUSE SERVICE

Provider reserves the right to refuse service to any patient on the account of any delinquent or unpaid fees for Services previously performed without any liability or further obligation to Client or Child.

4. TERMINATION OF SERVICES

Client shall have the right to terminate Services at any time upon written notice, and Provider shall immediately, after receiving such notice, cease to render additional Services. Such

termination will not, however, in any way relieve Client of the obligation to pay the fees and costs due for the Services rendered.

If Client fails to meet any of Client's obligations under this Agreement, Provider will, in its sole discretion, have the right to terminate this Agreement and immediately withdraw from providing Services to Client and/or Child. In the event Provider terminates this Agreement, Client shall immediately take all steps necessary to free Provider of any obligation to perform further Services hereunder. Withdrawal from representation by Provider shall not in any way relieve Client of the obligation to pay the fees and costs due for Services rendered.

5. DISCLAIMER & NO GUARANTEE OF OUTCOME

Those providing Services on behalf of Provider will make every good faith effort, utilizing their professional knowledge and expertise, to affect an appropriate result for Client, as it relates to Child. Client understands, acknowledges and agrees that results can in no way be guaranteed. As such, Client agrees to pay Provider any and all fees due and payable under this Agreement, whether or not desired results are accomplished or affected.

6. INSURANCE

CLIENT UNDERSTANDS, ACKNOWLEDGES AND AGREES THAT PROVIDER MAY OR MAY NOT WORK DIRECTLY WITH CLIENT'S INSURANCE CARRIER, AND THAT THE CLIENT SHALL BE SOLELY AND DIRECTLY RESPONSIBLE FOR THE FULL PAYMENT OF ALL FEES DUE AND PAYABLE.

7. PROFESSIONAL RECORDS

The laws and standards of Provider's profession require that Provider maintain the privacy of Child's Protected Health Information ("PHI"). Provider will not use or disclose PHI without the consent or authorization of Client for purposes other than treatment, billing or operations related to treatment and billing.

Provider will not release nor exchange Child's information with other healthcare professionals, other than a physician from which Child received a prescription/referral/medical clearance, without Client's consent. Should Client decide to grant Provider consent to release and/or exchange information to/with other professionals and/or caretakers involved in Child's care, Client is required to complete and sign the separate form entitled "Patient Consent to Release and/or Exchange Information."

Provider's personnel who release PHI for purposes including, but not limited to, insurance company requests, will release the minimum amount of information necessary based on the purpose of the request, and to the extent that such release complies with the law and satisfies the request.

Pursuant to HIPAA Compliance Policies and Procedures, Client's written authorization is not required for the following: judicial request, health oversight; law enforcement; public health activities; medical examiners and specialized government functions. Specialized government functions include, but are not limited to, disclosure about victims of abuse, neglect or domestic violence.

8. BINDING ARBITRATION OF DISPUTES

Client understands and agrees that any dispute between the parties to this Agreement, arising out of or in any way related to any provision of this Agreement and/or Services of Provider, including, but not limited to, disputes over fees or claims of malpractice, negligence, breach of contract, breach of fiduciary duty, fraud, or any other claim, shall be submitted to **BINDING ARBITRATION.** Such binding arbitration shall be undertaken by JAMS San Francisco, and the outcome of which shall be binding upon the parties.

The prevailing party to any such binding arbitration shall be entitled, in addition to such other relief as may be granted, to reasonable attorneys' fees and necessary costs and expenses as a result of such binding arbitration. The decision of the arbitrator shall be final and binding on the parties, and may be entered as a binding judgment of the parties by any court of competent jurisdiction. The prevailing party shall also be entitled to reasonable attorneys' fees, costs and expenses related to the enforcement of the arbitration decision, whether or not suit is filed.

CLIENT UNDERSTANDS, ACKNOWLEDGES AND AGREES THAT ANY AND ALL DISPUTES HEREUNDER SHALL BE SUBMITTED TO FINAL, BINDING ARBITRATION. AS SUCH, CLIENT UNDERSTANDS, ACKNOWLEDGES AND AGREES THAT, BY SUBMITTING ANY AND ALL DISPUTES TO BINDING ARBITRATION, CLIENT UNCONDITIONALLY WAIVES, FULLY AND FINALLY, ANY AND ALL CONSTITUTIONAL RIGHTS CLIENT MAY HAVE OTHERWISE HAD TO A JURY OR COURT TRIAL OF SAID DISPUTE

ARBITRATION CLAUSE UNDERSTOOD, ACCEPTED AND AGREED TO:

_____ _____

CLIENT DATE

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9. GENERAL WAIVER

In the event that any section, paragraph or portion of this Agreement is waived by mutual consent of the parties (whether by action or inaction), that waiver shall be only for that section, paragraph or portion of this Agreement actually waived, and only for that single instance. Any such waiver shall not constitute a waiver of any other provision of this Agreement, and shall not be considered a permanent waiver of that section, paragraph or portion of this Agreement.

The failure of Provider to enforce at any time any one or more terms, conditions, or provisions of this Agreement shall not in any way constitute a waiver of Provider's right to later enforce such terms, conditions or provisions of this Agreement. Furthermore, in no way shall course of prior dealing between the parties hereto constitute a waiver of any such terms, conditions or provisions to this Agreement.

10. SEVERABILITY

If any provision of this Agreement is deemed by a court of competent jurisdiction to be invalid, illegal or otherwise unenforceable, the invalidity of such provision shall in no way affect the validity of any other provision of this Agreement, and all unaffected, remaining provisions of this Agreement shall remain and shall be given full force and effect.

12. ENTIRE AGREEMENT

This Agreement constitutes the entire Agreement of the Parties, and supersedes any and all prior and contemporaneous negotiations and agreements, oral or written. All prior and contemporaneous negotiations and agreements are deemed incorporated and merged into this Agreement and are deemed to have been abandoned if not so incorporated. No representations, oral or written, are being relied upon by either party in executing this Agreement other than the express representations of this Agreement. This Agreement is UNDERSTOOD, ACCEPTED AND AGREED TO:

CHILDREN'S THERAPY ASSOCIATES

BY:_____ _____
MICHELLE FOOSANER, Director **DATE**

BY:_____ _____
CLIENT (SIGNATURE) **DATE**