Bloom & Be
Therapy and Educational Services

SERVICE CONTRACT

Scheduling

- In order to be placed on the schedule, we must have a copy of your intake paperwork and copies of your insurance card (if applicable).
- If using insurance, we also need a script from your doctor prior to scheduling.

Insurance/Billing/Fees

- Bloom & Be Therapy and Educational Services (from here on called "Bloom") is a credentialed provider with Indiana Medicaid (including managed health care providers for Hoosier Healthwise – MDwise, Anthem, Caresource, and MHS). We are also a credentialed provider with Anthem Blue Cross Blue Shield.
- We are currently out of network with all other insurance companies but can provide superbills to allow for families to submit for reimbursement if the insurance company allows. This is not a guarantee and varies by insurance company and plan. Prompt pay rates are available for clients who do not have insurance or those who have out of network insurance which does not cover their services. Please see "rates" page for details.
- Please provide a copy of your insurance card to Bloom along with your intake paperwork.
- Billable services include, but are not limited to: assessment, treatment, care-giver training, team meetings (when requested), and phone/email consultations of longer than 10 minutes.
    - Consultations of longer than 10 minutes must be scheduled and will be billed at half the therapy rate.
- Payment may be received by either card, cash, or check made out to **Bloom & Be Therapy and Educational Services**, upon delivery of service. Invoices and auto-charges are completed and delivered via Stripe email by the end of the therapy week.
- We are able to accept FSA/HSA cards.
- For clients outside of the Muncie/Anderson area we charge a flat travel fee of $25 if driving to the home/community setting. You will be made aware before your appointment if this applies.
- By signing this form, you agree to a credit card on file being charged for non-payments older than 30 days.

Balance Billing

- For those participating in out-of-network billing, clients are expected to pay any remaining balance following insurance payout.

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Clinic Expectations

- The type and delivery method of service will be determined together between caregivers and the therapist prior to or following the evaluation.
- You will receive an initial evaluation report following the first appointment and progress reports at least every 6 months.
- Receipts stating your "paid" status will be distributed monthly if not paying by credit card and receiving automatic receipts.

Appointments

- WE OPERATE USING A CLINICAL HOUR: Appointments may be 30, 45, or 60 minutes **including 5-10 minutes reserved at the end for parent review of session, session note-taking, preparation and explanation of home practice materials, and receipt of service fees.** Appointment length will be agreed upon following initial evaluation.
- When parents/caregivers are unavailable during therapy (for example, during teletherapy or when seen at a daycare or school), notes and materials will be provided for their review. They will be encouraged to integrate home practice into their daily routines and maintain open lines of communication with the service provider to support the client's communication development and goals.

Cancellations

- A late cancellation fee of $30 will be charged if therapist is not alerted of the need for cancelation with at least 24 hours notice. If more than 2 appointments are missed in a row or if you have only attended 75% of sessions in the previous quarter (whether the therapist is alerted or not), a discussion regarding termination of services may be initiated by the clinician.
- A $30 no-show fee will charged for missing a scheduled session without communicating prior.

Late Payments

- Payment is due at the time of service. If a Stripe invoice is preferred, payment is due within 5 days of receipt. After two sessions of non-payment, **therapy will be placed on hold** until the outstanding balance is paid. Client will be placed on the waiting list. Credit cards will automatically be charged for invoices that are 30 days late.

Privacy and Confidentiality

- Unless express verbal or written consent is granted by the client or care-giver, all information shared with this clinician will remain confidential, in accordance with HIPAA.

https://www.cdc.gov/phlp/publications/topic/hipaa.html. You acknowledge that you are responsible for any information sent by you over email.

Consent for Audio/Video Taping

- At times, audio and video taping may be deemed to be of clinical benefit during the assessment and treatment process. The materials will remain protected and the property of Bloom, and only shared with express consent from the client or caregiver. Your signature below gives your consent to such activities.

Release Waiver and Assumption of Risk

- I do hereby give my consent for my child to participate in the activities at Bloom & Be Therapy and Educational Services. I am fully aware that engagement in activities in the sensory gym area presents a risk of injury during treatment and evaluations. I am fully aware of and appreciate the risk and damages that might occur as a result of my child's participation in or attendance at Bloom & Be. Nonetheless, I, on my own behalf of my child and our heirs, administrators and executors, do hereby release, indemnify and agree to hold harmless Bloom and all persons or entities associated with Bloom from any responsibility or liability for any and all claims, demands, damages, costs, causes of actions and expenses (including, without limitation, reasonable attorneys' fees) arising out of or resulting from my child's participation in or involved with any therapy/evaluations, including without limitation, any personal injury, disability or property damages incurred or sustained by me or my child during or as a result of treatments/evaluations conducted by Bloom. I understand that the participant's family medical insurance policy must cover any medical costs incurred in case of an accident. I do hereby verify that I fully understand and accept the preceding conditions for permitting my child to participate in therapy/evaluations at Bloom.

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Therapy and Educational Services

My signature below indicates my acceptance of the terms outlined above in the Service Contract and my permission for treatment. I understand that services may not proceed without my consent.

_____ _____

Signature Date

My signature below indicates permission to automatically charge my credit card following a session. (If you do NOT give permission, an invoice will be sent that you will pay on your own within the 5 day timeframe.)

_____ _____

Signature Date

Thank you so much for being a client of Bloom & Be Therapy and Educational Services!