Center of Developmental Pediatrics
5757 Woodway Drive, Suite 202
Houston, Texas 77057
713.977.0730

Evaluation/Therapy Contract and Financial Agreement

I, ___________________________, hereby give my full consent for my child, ______________________________ , or myself to receive occupational therapy evaluation and treatment provided by Center of Developmental Pediatrics. If I am referring my child for services, I certify that I have legal responsibility for this child and am authorized to seek treatment for him or her. I understand that if any court reports, court appearances, or court attestations are required in association with occupational therapy services, I am responsible for payment in advance of a full fee for these services. I will give the Center of Developmental Pediatrics advanced notice of such services.

I am consenting to have any and all of the services rendered to my child or me:

1. **Occupational therapy evaluation and treatment as described in the *Occupational Therapy Practice Framework: Domain and Process, Occupational Therapy Rules, and Practice Act***
2. **Evaluation and Treatment including but not limited to: Sensory Processing/Sensory Integration, Motor Skills (fine, gross, strength, coordination), Visual Perception/Visual Motor, Handwriting, Activities of Daily Living, Instrumental Activities of Daily Living, Play, Leisure, Social Participation, and the associated Performance Skills, Patterns, Client Factors, Context, and Activity Demands**
3. **Caregiver education and consultation**
4. **Consultation with other health care personnel if requested.**
5. **Consultation with school administration, teachers, and support staff if requested.**

I agree to pay for these services as described below:

1. **Payment will be made prior to or at the time of service.**
2. **All cancellations made 2 hours or less prior to your scheduled session, will be charged 50% of the regular session fee. Any session where I did not notify Center of Developmental Pediatrics of the cancellation, I will be responsible for full payment of the missed session. Any late cancel or no show fees can not be billed through your insurance, and it will be my responsibility.**
3. **All scheduled conferences via phone, zoom, in person along with parent teacher conferences or school observations will be billed at the current cash rates and not billable for insurance reimbursement.**
4. **There is a $1/minute charge for all late pickups. It is expected that the caregiver return 5 minutes prior to the session ending to receive session feedback.**
5. **Center of Developmental Pediatrics cannot guarantee reimbursement from any insurance carrier. I am responsible for payment of this account.**
6. **I authorize Center of Developmental Pediatrics to discuss and/or release any necessary information to my insurance company to process insurance claims and to ensure continuity of care.**

Center of Developmental Pediatrics has informed me that questions and/or complaints may be directed in writing to:
The Executive Council of Physical and Occupational Therapy Examiners
333 Guadalupe, Ste 2-510
Austin, Texas 78701-3942
512-305-6900

Parent/Caregiver Signature________________________________ **Date**_______________