1815 NW169th Place, Suite 3070
Beaverton, OR 97006
Ph 971-249-2653
Fax 503-747-4373

PRIVATE PAYMENT CLIENT AGREEMENT

Client Name _____

Date of birth _____

Therapy claims are billed at a charge of $320 for an evaluation and $180 for speech therapy session, and $45 each 15 minutes for OT or PT session. A contractual adjustment will be made when claims are not submitted to insurance plans and paid at the time of service. If for any reason it is not paid at the time of service, payment must be made in full at the next treatment session to prevent suspension of future services.

I understand BOLD Pediatric Therapy Center will not bill my insurance plan and I agree to pay the charges for the following services:

☐ $290 for Evaluation ☐ OT ☐ SLP ☐ PT

☐ $130 Speech Therapy Intervention

☐ $32.50 per unit ☐ OT ☐ PT Intervention

☐ $50/half hour Consultation service. (This includes therapist attending a meeting requested by parents, in person or by distance format, providing a home visit or community visit beyond the scope of medical insurance covered services).

☐ $50/Report (Documentation other than evaluation and progress notes written after each session).

By signing this form, I am superseding the permission given to submit claims to the medical insurance plan.

This agreement will be in effect for one year from the date of signing. Revocation for termination of this agreement is not retroactive but will apply from the date BOLD Center receives notice of change.

Signed: _____

Relationship: _____

Date signed: _____