10605 Concord Street, Suite 102 • Kensington, MD 20895
Phone: (301) 933-7880 • Fax: (301) 933-7911

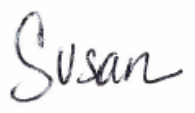
Susan Tieche, LLC
Susan R. Tieche OTR/L and Associates
S.I.P.T. Certified
MD License #03853
Pediatric Occupational Therapist
www.its-dts.com

Phone:(301) 933-7880, ext. 4 **Email: stieche@aol.com** **Fax: (301) 933-7911**

This packet contains forms to be completed and returned to the mailing address below, emailed, or faxed 2 days prior to your appointment. If you fax the forms, please bring the originals on the day of the appointment as at times faxes are unclear. Please return pages 3 through 10 along with any additional information such as school or therapy reports. Should you have questions about the completion of these forms, please call (301) 933-7880, ext.4 or email Susan at stieche@aol.com. :

Susan Tieche OTR/L
ITS: Developmental Therapy Services, INC.
10605 Concord Street, Suite 102
Kensington, MD 20895

Thank you,



Susan Tieche, LLC
Susan R. Tieche OTR/L and Associates

Pediatric Occupational Therapist **Private Practice&**
S.I.P.T. Certified **Consultation**
MD License # 03853

Current Fee Schedule, Payment Policy, and Cancellation Policy

The following is the current Fee Schedule, Payment Policy, and Cancellation Policy for services to be provided to you or your child by Susan Tieche, LLC and/or its consultants (the "Company"). Please understand that the Company reserves the right to change and/or modify the fees set forth below, but you will receive thirty (30) days advanced notice of any increase in such fees. All fees and costs shall be due and payable in accordance with the Agreement to Terms of Payment.

Fee Schedule:

Individual Therapy:

Office Visit/Treatment - *$132.00 per Hour*
Consultations/Evaluations - *$150.00 per Hour*

Hourly consult/evaluation fees include any test administration and scoring, evaluation write-up, parent conference, teacher conference, fine motor/handwriting evaluations, school observation, telephone consults with related service providers or parents, written reports for insurance companies, review of reports, and/or any allocated time on behalf of the client.

*All hourly rates are billed in 15 minute increments.

*A comprehensive evaluation, including the Sensory Integration and Praxis Test, is $135 per hour with a maximum charge of $945.

Payment for Services

For your convenience, we accept Visa and MasterCard. We do not accept American Express. **We do not accept checks**. Credit Card charges will be processed on the first day of each month and itemized statements will be sent to you in PDF form via electronic mail; unless you request otherwise.

All correspondences regarding billing should be emailed to Susan at stieche@aol.com or mailed to this address:

Susan Tieche, LLC
C/o ITS: Developmental Therapy Services, INC.
10605 Concord Street
Suite 102
Kensington, MD 20895

Cancellation Policy

There is no charge for cancellations made prior to 7:30 a.m. on the day of treatment. If the cancellation is made after 7:30 a.m. on the day of treatment, the session will be billed at the full rate if the session cannot be filled. If you need to cancel, please contact your therapist directly to cancel your appointment. Appointments that are not cancelled are considered "no-shows". These appointments will be billed at the full rate.

Susan R. Tieche OTR/L and Associates
Pediatric Occupational Therapist

Phone (301) 933-7880, ext. 4 **email: Stieche@aol.com** **FAX: (301) 933-7911**

Referral Form

Name: _____

Date of Birth: _____

Mother's Name: _____

Father's Name: _____

Address: _____

Ph number: H:_____; Mother's mobile: _____
Father's mobile: _____Other:_____

Current School or Program: _____Grade: _____

Teacher Name and Contact Information:_____

I, _____(print name), authorize Susan R. Tieche OTR/L and Associates to communicate with me via electronic mail, _____(enter email address), regarding scheduling and any clinical information about my child.
_____.
(Signature and date)

Please describe your **parental concerns** and **primary referral reasons**:
(Please include any **medications** or **allergies/special diets**)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

– Referral Form, CONTINUED

Briefly describe pertinent medical history such as any **surgeries**, **birth trauma, medical diagnoses, injuries,** or any **history of seizures** (or attach reports that will summarize the information.):

Describe current health status:

Please briefly describe **developmental** and **therapeutic** history or any **learning challenges** your child has:

Susan Tieche, LLC
Susan R. Tieche OTR/L and Associates
Pediatric Occupational Therapist

Name of child: _____
Date: _____
DOB: _____
Referred by: _____

School: _____
Address: _____
Telephone: _____

Teacher: _____
Telephone: _____

Occupational Therapist: _____
Telephone: _____
Address: _____

Physician: _____
Telephone: _____
Address: _____

Speech Pathologist: _____
Telephone: _____
Address: _____

Psychologist/Psychiatrist (circle one):_____
Telephone: _____
Address: _____

Educational Consultant: _____
Telephone: _____
Address: _____

Optometrist/Ophthalmologist (circle one): _____
Telephone: _____
Address: _____

Neurologist:_____
Telephone:_____
Address:_____

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Consent Form

Name	Telephone Number	Initial/Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____ _____
Signature Initial Date

I, _____(Print Name) give my permission to Susan R. Tieche OTR/L and Associates to speak with the above listed professionals regarding my son/daughter _____.

Susan Tieche, LLC
Susan R. Tieche OTR/L and Associates
Pediatric Occupational Therapist

Phone:(301) 933-7880, ext. 4 email: Stieche@aol.com FAX: (301) 933-7911

Consent to Release Form

I, _____ (*print name*) give my permission and consent to Susan Tieche, LLC, Susan R. Tieche OTR/L, and their respective consultants and agents (hereinafter, collectively, the "Company") to discuss and speak with school officials, teachers, psychiatrists, medical doctors, other occupational therapists, insurance representatives, and other professionals (collectively, "Third Party Professionals") regarding my child (or the child under my care) as such may be needed in connection with the treatment and/or evaluation of such child by the Company.

In addition, the Company is authorized to receive any records, files, charts, and other documentation and information from such Third Party Professionals, and by signing this document, the undersigned is authorizing the release of any such information that may be held by a Third Party Professional to the Company. Any person who is provided a copy of this document may rely on it as the undersigned's full and unconditional consent to the release of any and all information pertaining to the child. The undersigned further authorizes the Company to release any and all information pertaining to the treatment and/or evaluation of the child to any Third Party Professional that may in any way be involved in the treatment and/or evaluation of the child.

The undersigned understands that some or all of the information obtained and/or released under this document may be protected under federal regulations including but not limited to HIPAA. By authorizing a release of information, as set forth above, the undersigned understands and agrees that they are agreeing to the release of such information notwithstanding the protections under HIPPA, provided, however, it is understood and agreed that the Company will maintain the confidentiality of any information obtained and will not disclose the same except as needed in the course of treating or evaluating the child.

The undersigned, for his/herself and his or her successors and assigns, does hereby hold the Company harmless from any and all claims relating to the release of information as provided above, and do hereby waive and release any claim against the Company relating to the release of such information as provided above.

AGREED AND ACCEPTED:

_____ _____
Signature Date
Print Name:_____

Susan Tieche, LLC
Susan R. Tieche OTR/L and Associates

Pediatric Occupational Therapist
S.I.P.T. Certified

Private Practice &
Consultation

Agreement to Terms of Payment

I, _____(*print name*), acknowledge and accept full and complete responsibility for payment of all services rendered to myself, my child, or any child under my care by Susan Tieche, LLC and/or its consultants. I acknowledge that I have received written explanation of the fee schedule, cancellation policy, and payment policy and I agree to both. I understand if I have any dispute regarding my credit card charges for occupational therapy services or late cancellation fees, I have 30 days from the date of the credit card transaction to contact Susan R. Tieche OTR/L and Associates. If I do not contact Susan R. Tieche OTR/L and Associates within 30 days of the credit card charges for the fees in question, the original credit card charges remain. I also agree to contact Susan R. Tieche, LLC with new credit card information as soon as possible should the card on file be breached. I understand I will incur any charge back costs/fees incurred to Susan R. Tieche, LLC as a result of charge backs from credit card breach.

I understand that health insurance policies are an arrangement between my insurance company and myself, that all services rendered to my child or any child under my care are charged directly to me, and that I am personally responsible for payment. I understand that agreements regarding fee schedules, charges for cancelled appointments and late payment fees are between myself and Susan Tieche, LLC, and are not related to potential insurance coverage. I understand that Susan Tieche, LLC may assist me in completing forms to aid in collecting insurance benefits for services that are billable, but ultimately it is my responsibility to complete and file such forms. I agree to the release by Susan Tieche, LLC and/or its duly authorized agents of any information that is requested by my insurance company.

_____ _____

Date

Signature of parent or legal guardian
Print Name:_____

Susan R. Tieche OTR/L
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Pediatric Occupational Therapist **Private Practice &**
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Credit Card/ Debit Transaction Processing Authorization Form

☐ Yes, I would like you to automatically charge my credit card for services rendered each month.

Card Type Number Exp. Date 3 digit code

◯ **VISA** _____ _____ _____ _____

Billing Address and Name on the card:

_____

_____

_____

Number Exp. Date 3-digit code

◯ **MASTERCARD** _____ _____ _____

Billing address and Name on the card:

_____

_____

_____

By signing this Agreement, and marking the box noted above, the undersigned does hereby agree as follows: (i) the undersigned does hereby authorize and agree that Susan Tieche, LLC and/or its duly authorized agent (the "Company") has the right from time to time to charge to the above identified credit card and/or debit the account identified above any and all amounts that are owed to the Company and/or its consultants, (ii) the undersigned agrees that its signature on this Agreement shall be deemed its signature on any sales charge receipt or other form and if any merchant services, credit card company, or bank requests to view the undersigned signature on a sales charge receipt or other form, the Company may provide such company with a copy of this Agreement and such shall be deemed conclusive proof that the undersigned approved and authorized the charge and/or debit at issue, and the undersigned does hereby waive any right to dispute its authorization to such charge based on an invalid or non-existent signature. The undersigned understands and agrees that the above payment option and charges or debits will continue each month for services rendered by the Company and/or its consultants until such time as the undersigned has provided written notice to the Company to stop such automatic charges and/or debits. The undersigned shall be fully responsible for ensuring that it has sufficient credit and/or funds to cover the charges or debits, and shall indemnify the Company against all costs incurred as a result of any declined charge or debit.

AGREED AND ACCEPTED:

Cardholders Signature:_____ Date:_____

Print Name:_____

*All credit cards will be processed on the first day of each month.

I,_____ authorize Susan Tieche, LLC and Associates to email paid invoices in PDF form to the following address_____.Date_____

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ACKNOWLEDGEMENT AND ASSUMPTION OF RISK

I, _____ (*print name*) acknowledge and agree to have myself, my child, or any child under my care, _____ (*print child's name*) receive occupational therapy services from Susan Tieche, LLC, Susan R. Tieche OTR/L and/or any independent contractor under the foregoing at ITS: Developmental Therapy Services, INC. I acknowledge that there is some risk inherent in the use of the therapy equipment and I agree to assume such risk and indemnify and hold Susan Tieche, LLC, Susan R. Tieche, any of their independent contractors, and ITS: Developmental Therapy Services, Inc. harmless from any and all losses and claims for any injuries or other damages occurring to myself, my child or our belonging.

_____ _____
Signature Date
Print Name:_____

PARENTAL CONSENT

I, _____ (*print name*), give my permission to Susan Tieche, LLC, Susan R. Tieche OTR/L, and their consultants (hereinafter, collectively, the "Company") to observe my child (or the child under my care) _____, at _____ School. I understand
that during this observation, the Company may speak with the classroom teacher and other professionals at the school about my child.

_____ _____
Signature Date
Print Name:_____

GENERAL ACKNOWLEDGMENT OF FORMS

I do hereby acknowledge and agree that: (i) I have read all of the forms and documents provided to me in connection with the treatment and evaluation of my child (or the child under my care) by Susan Tieche, LLC, Susan R. Tieche OTR/L and/or their respective consultants; (ii) I understand the meaning and intent of such forms, and agree to the provisions contained therein; (iii) I have been given the opportunity to ask questions concerning the forms and any questions that I have asked have been answered to my satisfaction, and (iv) I have signed all of the forms upon my on free volition and without any coercion from any third party.

Date:_____

_____
Signature of Parent/Guardian
Print Name:_____