Our Service Arrangement

Your Privacy.
We are bound by the Privacy Act 2001 to obtain your consent to collect personal information. The personal information collected and maintained by our Practice comprises your child's name, birth date, address and contact details. We will also collect information specific to your child's current situation, and to the services being provided to you. The purpose of collecting this information is to assist the best outcome for your child. Due to the sensitive nature of this information, we must obtain your written consent to proceed with our services.

To effectively assist you, we must exchange information between your doctor, other treating providers, insurer and any other parties associated with your child's need. This information will only be disclosed for its intended primary purpose or in some situations for secondary purposes such as administrative ones. In exceptional cases such as legal reasons, we may be required to disclose your child's personal information.

Record keeping.
This Practice ensures that you and your child's personal information is stored securely and is only accessible to authorized employees. Information for billing purposes, such as credit card details, is stored on the database system of the Practice, which is password protected. Please inform us of any changes in yours or your child's information, so that our records can be updated. At any time, you may request access to your child's file. Please allow us some time to arrange this, so that the treating therapist may be present to discuss contents of the file with you.

Payments & Cancellations.
Bounceintolife! Children's Occupational Therapy accepts payments of invoices by Credit card or Electronic Funds Transfer (EFT).
Invoices will be sent via email following each consultation and are payable within **7 days** from the date of service provision.
We require Credit or Debit card details to be listed on a password-protected system for all clients. If Credit or Debit card has not been selected as the preferred method of payment, the card will only be debited in the instance of accounts being in arrears (7 days from date of service).
Overdue payments will incur an initial $10 late fee and any other costs incurred if referred to a Debt Collection Agency.
You will be alerted if your account becomes in arrears of any amount greater that $220. bounceintolife! reserves the right to limit service provision until arrangements for payment are made.

Notice of Appointment Cancellation must be provided to the therapist **by 8 am** of the day of the scheduled visit. Failure to do so will result in a $30 cancellation fee (except for exceptional circumstances – at provider's discretion).

Care Plans : (Includes Mental Health Care Plan, Chronic Disease Plan, Helping with Children with Autism)
Mental Health Care plans are bulk billed, with Medicare being billed direct
Partly funded care plan sessions (Chronic Disease plan and Helping Children with Autism) require full payment within 7 days of service provision. You are then required to send receipt to Medicare for reimbursement.
In the event that this does not occur, we will debit your Credit/ Debit card as discussed above.

FaCSHIA funding : Refer to Provider website for fee schedules (www.fahcsia.gov.au) Additional Paperwork will be completed for clients accessing this funding.

Fees for service:
$110.00/ 45-60 min session – therapy session, educational meeting attendance.
$400.00/ Assessment session (90-120 minutes + written report to be provided to you within a 2 week period).

Please list **names, telephone numbers and addresses** for those people, apart from yourself, **whom you want** information to be shared with.

Teacher____

Psychologist____

SpeechPathologist____

FamilyDoctor____

Paediatrician____

Other____

Please list **names and addresses** for those people, apart from yourself, **whom you <u>do not</u> want** information to be shared with.

Name: ____

Occupational health & safety

Bounceintolife! requires you to have in place and to maintain, to the extent reasonably practicable, a safe home environment for the visiting therapist. This includes a non-smoking environment.

INFORMATION CONSENT

I am the parent/carer or legal guardian of ____.
I have read and understood the above information.
I understand that if my child's information is used for any other purpose, further consent will be obtained.
I hereby consent/ do not consent for another nominated 'responsible other' person such as my child's school teacher signing forms for claiming such as FaHCSIA Early Intervention Autism Packages & Better Start .
I hereby consent to the handling of my information by this Practice for the purposes set out above.

Name : ______________________________ Witnessed by : ______________________________

Signature : __________________________ Signature : ________________________________

Date : ___________________ Date : ___________________

Please provide your medicare and credit card details on the form attached. Once this information has been entered into our secure electronic system, this form will be immediately shredded.

T: 08 8234 2852 **M:** 0419 189 620 **E:** admin@bounceintolife.com.au
PO Box 189, Torrensville Plaza, South Australia 5031

ABN: 72 708 539 462

Payment Information :

Medicare Card:

Name of child: ___________________________

Medicare number : __________________________ Patient no. ____

Expiry date : _______________

Credit Card Details:

Name on card : _______________________________

Number on card : ______________________________

Expiry date : __________________________________

CCV : ____________

bounceintolife.com.au

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