FOUNDATIONS
Dyslexia & Learning Centers
foundationsdlc.com
BLOOMINGTON • COLUMBUS • SEYMOUR

Agreement for Services

Assessment

I understand that the services provided by Foundations Dyslexia and Learning Centers will determine whether or not my child fits the dyslexia profile, but it may not qualify my child for Special Education services or a 504 Plan in the public and private school systems. This process is **not** intended for use in determining eligibility for school-based intervention but may prove beneficial in your child's overall educational plan.

Foundations Dyslexia and Learning Centers do not accept medical insurance as payment. Medical insurance does not cover screening for dyslexia and generally does not cover psycho-educational testing because it is not considered to be medically necessary and is not a covered service under most insurance plans. I understand that I may request a statement from Foundations regarding these services that I can provide to my insurance company in order to seek any reimbursement from them. Furthermore, I understand that it is my responsibility to file any information with my insurance company, if I so choose, and regardless of my medical benefits, I am fully responsible for payment to Foundations Dyslexia & Learning Centers.

The dyslexia assessment process will determine whether or not my child fits the classic profile of dyslexia and will offer recommendations for intervention.

I agree to pay for the following services (check one):

- ☐ Consultation only: $150
- ☐ Consultation, Dyslexia Diagnostic Assessment, and Report: $550
- ☐ Consultation, Comprehensive Evaluation, and Report: $550 with additional amount to be determined based on my child's specific needs

_____ _____

Signature of Client/Legal Guardian Date

Consent and Treatment

I, _____, the undersigned, hereby attest that I have voluntarily entered into services, or give my consent for the minor or person under my legal guardianship, _____, to receive services at Foundations Dyslexia and Learning Center of Bloomington, hereby referred as Foundations. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the services provided may be discontinued at any time by either party. Foundations encourages that this decision be discussed with the director of Foundations. This will help facilitate a more appropriate plan for discharge. _____ (initial)

Non-Voluntary Discharge from Treatment

A client may be terminated from Foundations non-voluntarily, if: A) the individual exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or B) the individual refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The individual will be notified of the non-voluntary discharge by letter. The individual may appeal this decision with the director of Foundations or request to reapply for services at a later date.

_____ (initial)

Client Notice of Confidentiality

The confidentiality of client records maintained by Foundations is protected by Federal and/or State law and regulations. Generally, Foundations employees may not say to a person outside of the Center that a patient attends the program or disclose any information identifying an individual as receiving services unless: 1) the individual or guardian consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation. Federal law and regulations do not protect any information about suspected child abuse or neglect or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. _____ (initial)

Parents or legal guardians of non-emancipated minor clients have the right to access the child's records. _____ (initial)

When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about an individual, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

_____ (initial)

Missed Appointment Policy

I understand that I will attend each scheduled appointment. If I am unable to attend, I will call to cancel the appointment within 24 hours. I understand that I may be charged a tutoring session fee of $55.00 if I give less than 24 hours notice, and I will

be responsible for this charge. I understand that future appointments may not be scheduled until this fee is paid. _____ (initial)

Agreement to Pay for Professional Services

I have been informed of the costs of services and understand that I am responsible for the cost of services in their entirety. I understand that it is my responsibility to contact my insurance company to determine if my insurance company provides coverage for any of these services. I also understand that Foundations will provide me a statement of services, at my request, if I choose to submit information to my insurance company. _____ (initial)

Payment Arrangements

☐ I give Foundations Dyslexia and Learning Centers permission to charge my credit or debit card if my account has a balance over 90 days past due, including missed appointment fees.
*This information will be kept in your confidential file

Credit Card # _____

Mastercard _____ Visa _____ Discover _____ American Express _____

Exp Date: _____ 3-Digit Code _____

Printed Name on Card: _____

Signature: _____ Date: _____

I consent to treatment and agree to abide by the above stated policies and agreements with Foundations Dyslexia and Learning Center of Bloomington.

_____ _____
Signature of Client/Legal Guardian Date

_____ _____
Witness Date