Initial [ ] Renewal [ ] Renewal w/ Changes [ ]

TREATMENT PLAN

(Initial & Renewal)

(Revised 11/17)

THIS IS A TREATMENT PLAN entered into by the following named parties pursuant to a program of the EUGENE F. HERMAN SCOTTISH RITE CHILDHOOD LANGUAGE DISORDERS CLINIC, INC., A Montana Public Benefit Corporation for sponsoring speech and language therapy for children with offices at 514 14 th Street W., Billings, MT 5102.

CLINICAL PROVIDER	**PARENT/GUARDIAN**	**CHILD/PATIENT**
_____	_____	_____
(Name of clinician)	(Father) (Guardian)	(Name)
_____	_____	_____
(Name of clinic)	(Mother)	(Date of Birth)
_____	_____	
(email address of clinic)	email address to contact if authorized)	

PLAN

Beginning date of initial 6 month plan period: _____(completed by Scottish Rite)

Ending date of initial 6 month plan period:_____ (completed by scottish Rite)

If a renewal, ending date of most recent plan period: _____ (completed by applicant)

Number of sessions per week: _____ [or] Number of sessions per month: _____

IF A RENEWAL: Has there been any significant changes in the financial condition of the parents or child since the most recent application? Yes [ ] No [ ]

PAYMENTS FOR CLINICAL SESSIONS

Charge per session ..... $ 80.00
Contribution by parent/guardian per session..... $_____
Insurance payment .....$_____
Payments received from other sources .....$_____
Balance paid by Scottish Rite..... $_____

Parent/Guardian agrees to:

A. Timely make agreed payments to Treatment Plan
B. Make and keep appointments as scheduled by clinician.
C. Promptly pay insurance proceeds to clinician for credit to Treatment Plan.
D. Promptly report all available sources for funding Treatment Plan to clinician.

CONSENT TO TREATMENT AND WAIVER OF MEDICAL PRIVILEGE

The undersigned parent/guardian, individually, consent and agree to the clinical treatment for the above-named child pursuant to this Treatment Plan by the Clinical Provider and waive all medical privilege and rights of privacy that would otherwise attach to said clinical treatment and record keeping as to all clinician, clinics, clinical staff and the members of the board of directors of the Eugene F. Herman Scottish Rite Childhood Language Disorders Clinic, Inc. And its clerical staff.

SIGNATURES OF THE PARTIES

EUGENE F. HERMAN SCOTTISH RITE
CHILDHOOD LANGUAGE DISORDERS Clinic, Inc.

X_____By its:_____ Date Signed _____

PARENT/GUARDIAN

x_____Date Signed _____ x_____Date Signed

_____ _____

(Print name & relationship to child) (Print name & relationship to child)

CLINICAL PROVIDER

_____

(Name of Clinic)

x_____(Date Signed)

(Clinician)