



Treatment Plan (Revised 9/1/21)

Directions: Information required by “solid black boxes” must be completed before submitting this Treatment Plan for approval by Scottish Rite. For **Renewals**, please submit during the last three weeks prior to the expiration of the previous Treatment Plan.

Plan Identification (by Parents/Clinician)

Initial ____; **Renewal w/ no changes** ____; **Renewal w/revisions** ____; **Change of Clinic** ____

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 (Scottish Rite, Rite Care), of sponsoring speech and language therapy for children, with offices at 514 14th Street West, Billings, MT 59102.

Parties (by Clinician)

Name of Child	Date of Birth	Phone Number
Name of Clinic/Clinician	Clinician’s email address	
Parent to be contacted	Parent’s email address	
Parent		

Treatment for Plan Coverage (by Clinician)

The Clinician finds that the child requires _____ treatment sessions per _____.

Term (by Scottish Rite)

INCLUSIVE DATES OF SIX-MONTH TREATMENT PLAN (By Scottish Rite)

Initial period from _____ to _____.

For renewals, the most recent Treatment Plan ends _____.

This Treatment Plan is approved for the period beginning _____ to and including _____ after which it is expired.

Expiration Date

By Parents or Clinician

NEW OR CHANGED INFORMATION

If this is a renewal Treatment Plan, attach a statement on a separate sheet of all significant changes, if any, in the financial condition of the parents or clinical needs of the child for this plan period.

ALLOCATION OF PAYMENTS FOR CLINICAL SESSIONS (By Scottish Rite)

Charge per clinical session..... \$80.00
Contribution by parents/session.....\$ _____
Insurance payments..... \$ _____
Payments from other sources..... \$ _____
Sponsorship by Scottish Rite \$ _____

Coverage of Plan: Scottish Rite is the “payor of last resort”. Payments from all sources are credited to reduce the payment from Scottish Rite. Sponsorships are granted for periods when insurance coverage does not pay.

AGREEMENT (Parents & Scottish Rite)

In consideration of the Scottish Rite Sponsorship program, parents agree to:

- A. Timely make the payments required by this Treatment Plan to the Clinician/Clinic.
- B. Make and keep appointments scheduled with the clinician.
- C. Promptly pay any relevant insurance payments received to the clinic/clinicians.
- D. Timely report all available funding for this Treatment Plan to the clinic/clinician.

CONSENT TO TREATMENT AND WAIVER OF MEDICAL PRIVILEGE

Parents jointly and severally agree to the clinical speech and language treatment for the above-named child pursuant to this Treatment Plan by the named clinical provider and waive all medical privilege and rights of privacy that would otherwise attach to said medical treatment and associated record keeping as to all clinicians, clinics, clinical staff, clerical staff and members of the board of directors of the Eugene F. Herman Scottish Rite Childhood Language Disorders Clinic, Inc.

SIGNATURES

Parents			
_____	_____	_____	_____
Signature	Date	Signature	Date

Clinician		
_____	_____	_____
Signature	Clinic	Date
email: _____		

For Eugene F. Herman Scottish Rite Childhood Language Disorders Clinic, Inc (Scottish Rite Rite Care)

by _____ its _____, _____

Signature

Office/position

Date