Initial__Renewal___Renewal w/ Revisions ___

Treatment Plan
(8/18)

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

PARTIES (By clinician)

______________________	__________	
Name of Child	DOB	
______________________	____________________	
Name of Clinic/Clinician	Clinician's email address	
______________________	____________________	_________
Parent to be contacted	email address	Phone No.
______________________		
Parent		

Treatment for Plan Coverage (By Clinician)
The clinician finds that the child requires ____treatment sessions per _______.

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.
Requests to renewal or extension of this Treatment Plan must be received by Scottish Rite prior to the expiration date. If additional sponsorship is sought after expiration of the most recent Treatment Plan, a new application is required.

NEW OR CHANGED INFORMATION (By parent[s] or Clinician)
If this is a renewal Treatment Plan, state all significant changes in the financial condition of the parents or clinical speech and language treatment needed during the period covered by this plan.

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 ....$_____

NOTES RE PAYMENT:

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 appoints scheduled with the clinician.
C. Promptly pay any relevant insurance payments received to the clinic/clinician.
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

Eugene F. Herman Scottish Rite Childhood Language Disorders Clinic, Inc.

x____________________________________by its___________________date_______________
Parents
x____________________________
x____________________________

CLINICIAN
x____________________________clinic____