MedStar Georgetown University Hospital

Welcome to Pediatric Therapy at Medstar Georgetown University Hospital!
In order to provide the most efficient and effective service, we request that you adhere to the following guidelines:

1. New evaluations will last 60-90 minutes, depending on the needs of your child. Weekly therapy treatment is scheduled for 45 minute intervals on the hour (e.g., 4:00-4:45); however, sessions can be shortened/lengthened according to the therapist's discretion and/or the patient's tolerance to treatment. **If you arrive more than 15 minutes late for your appointment, your child may not be treated. If you arrive late to your scheduled appointments repeatedly, your therapist has the right to discharge your child from therapy.**
2. In order to minimize disruption and ensure safety, space, and privacy during therapy sessions, one or two adults may accompany a child during treatment. **Your child's siblings should stay in the waiting room with adult supervision during the treatment session.** If this is not possible, other child-care arrangements must be made. If you need to leave the treatment session or waiting area, you must remain within the hospital and provide the therapist with your cell phone number in case of an emergency. **In case of emergency, it is important that we are able to find you. If you leave the hospital and/or cannot be reached by phone when contacted by therapist, this may be grounds for discharge from therapy services.**
3. Please do not bring your child to therapy if he/she is sick. Your child's therapy session will not be productive and we do not want to put other patients or therapists at risk for infection. Please call our front office at **(202) 444-4180** to cancel the appointment (24 hours notice, when possible, is greatly appreciated!).
4. Please call in advance to advise us of a cancellation. If you do not call in advance, the appointment will be put in your chart as a 'no show.' **Accumulating repeated "no shows" may result in the termination of therapy appointments.**
5. Ensure your child is present for the majority of their scheduled appointments. **If a patient attends less than 75% of appointments within a 2 month period, he/she may be discharged from therapy.** A new doctor's order will be required to schedule a reevaluation to resume services.
6. The child's parent/guardian is responsible for providing a medical prescription for his/her therapy services for the first visit and as requested by the therapist. **Patients without a written prescription from his/her doctor cannot be seen for therapy.** The doctor's orders may be brought to the department or may be sent by fax to **1-855-470-6848**.
7. You will be asked to complete a Caregiver Release Form if you delegate other persons to pick up and/or drop off your child. **If someone other than a parent or legal guardian brings a child to therapy without the form filled out we will not be able to treat the child**. **As your child's guardian, it is required that you remain within the hospital during your child's appointment. You may not leave the hospital during your child's appointment. If we cannot reach you in the event of an emergency, your child may be discharged from future therapy services.**
8. If additional evaluation or therapeutic services (i.e. developmental evaluation, early intervention services) are recommended during your assessment but not scheduled, **your therapist(s) has the right to discharge your child from therapy if progress is not demonstrated.**
9. The child's parent(s)/guardian is responsible for advising the therapist if there is any change in medical status (weight bearing status, acute illness, new diagnosis, etc). If the change in medical status may affect your child's treatment, you must get a new prescription from his/her doctor to continue therapy.
10. If a patient has a co-payment, it must be paid before each session. This is regulated and monitored by each patient's insurance. If a co-payment is not made each visit, the patient may be responsible for the financial charges of each visit.

I have read and understand my responsibilities as a parent/guardian printed above and agree to abide by them.

Parent/Guardian Signature_____ Date _____

Patient Name: _____ DOB: _____

Therapist Signature _____ Date _____