



# PLAY PROJECT SERVICES AGREEMENT

This **PLAY Project**™ Services Agreement (“Agreement”) is entered this \_\_\_\_ day of \_\_\_\_\_, 201\_\_ (“Effective Date”), by and between LEGAL NAME OF ORGANIZATION, of ADDRESS (“NAME”), on behalf of **The PLAY Project**™ Play and Language For Autistic Youngsters also referred to as “PLAY Autism Intervention” (the “Program”) developed by Richard Solomon, MD of PLAY Project organization, and \_\_\_\_\_ (collectively, “Family”) of \_\_\_\_\_ (home address), parents or legal guardian of \_\_\_\_\_ (“Child”), who will participate in the Program.

## RECITALS

**WHEREAS**, NAME provides a Program, the purpose of which is to provide early intervention therapy services for children with autism and training services to the care givers(s) of the Child; and,

**WHEREAS**, the Family wishes to obtain Program services on behalf of the Child from NAME.

**NOW THEREFORE**, the parties wish to formalize this relationship, and in consideration of the mutual promises set forth herein, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties hereby agree as follows:

**Section 1. Obligations of NAME.** Pursuant to the terms and conditions of this Agreement, NAME agrees to provide the Program in \_\_\_\_ (\_\_\_\_) sessions of training, therapy, and evaluation services (collectively, “Therapy”) for the Child which shall include supervision of PLAY consultation services delivered by \_\_\_\_\_ (“Consultant”). A Therapy session typically lasts three (3) hours, exclusive of PLAY Consultant’s travel time. It is understood and agreed that other types of treatment or care, not specifically mentioned herein, are independent of this Agreement and should be discussed and agreed upon by NAME and Family. Any increase in services provided by NAME at the request of Family shall be by written mutual agreement only. Given the finite amount of services available, the Program may not be able to provide more services than has been agreed to herein.

**Section 2. Obligations of Family.** Pursuant to the terms and conditions of this Agreement, Family hereby agrees to:

- (a) Ensure the attendance and participation of the Child in the Therapy; and,
- (b) Provide information about the Child to NAME and the PLAY Consultant by attending and participating in scheduled visits, completing requisite forms and reports, and generating videotaped data and other information which may be requested by NAME from time to time.

**Section 3. Compensation.** Pursuant to the terms and conditions of this Agreement, Family shall pay to NAME the sum of \$\_\_ (\_\_\_\_\_) plus Travel Fee (as defined below) in exchange for \_\_\_\_ (\_\_\_\_) sessions of Therapy provided hereunder



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during the initial \_\_\_\_ (\_\_\_\_) month term of this Agreement. As per line 9 from the Financial Worksheet in Table A, the total cost of Therapy due under this contract is \$\_\_\_\_\_.

Family agrees to pay a fee to cover the expenses of the PLAY Consultant traveling to the Therapy session ("Travel Fee"). This fee will be determined by the round-trip distance ("Zone") that the PLAY Consultant must travel, as per Table B.

A required non-refundable deposit covering the first (1) visit plus Travel Fee shall be due and payable upon the signing of this Agreement (the "Deposit"). As per the Financial Worksheet in Table A, the total Deposit due is \$\_\_\_\_\_(from line 4). Additional non-refundable payments of \$350.00 (three hundred fifty) shall be due and payable each month for \_\_\_\_ (\_\_\_\_) months following the Effective Date. NAME will issue an invoice at the beginning of the following month: \_\_\_\_\_, 201\_\_\_\_ (from line 5) and the Family's first monthly payment will be due by the end of that month. As a condition of this agreement, Family is responsible for making monthly payments and an invoice will be sent monthly as a reminder. Family will complete Table C: Payment form to indicate preferred method of payment for both Deposit and Monthly amount.

**Section 4. Payment Policy.** The Program depends on the Family's payment for the services in a timely fashion. NAME expects that Family will make payments in advance of services provided. After the initial Deposit, a monthly billing and payment system has been structured as follows:

- A reminder invoice will be prepared during the first week of each month, beginning with the month specified above.
- Payment is due by the end of each month.
- If payment is not received more than fifteen (15) days after the payment due date, it will be considered late and the services provided to Family by NAME may be discontinued until all payments are received.

**Section 5. No-Show Policy for Home visits (if applicable).** If the Consultant visits a home for a scheduled visit and the Family and/or Child is not home, the Home Consultant will wait for twenty (20) minutes before leaving. If the Home Consultant leaves, a fee of \$100 (one hundred dollars) will become due and payable, the visit shall not be made up and Family will be charged for the visit as if the same had occurred.

**Section 6. Cancellation of Visits.** If Family elects to reschedule a visit by the PLAY Consultant, Family must contact its PLAY Consultant directly at least 24 hours in advance of his/her scheduled visit. Clients will be charged a \$50 fee for visits cancelled within 24 hours, except for family emergencies and/or illness. These fees are in addition to the monthly fee. Excessive cancellations may result in loss of visits and Family will still be charged and required to pay for the visits. If your Home Consultant cancels the visit, it will be rescheduled promptly according the schedules of the parties. Visits cancelled during the last month of this Agreement will not be rescheduled and families will still be charged for the price of the visit.

**Section 7. Termination of Agreement.** If this Agreement needs to be terminated early for any reason, notice of such termination shall be in writing and submitted at least 30 days prior to the termination date. A fee of \$100.00 (one hundred dollars) will be accessed as a processing fee for early



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terminations elected by Family. As noted above, all payments are non-refundable. Families will be billed and must pay for any visits that have been received up to the date of termination notice. If a visit is scheduled within the 30 day period after notification and has not yet been paid for, the Family will be billed and must pay for the visit, whether or not they choose to receive this visit.

**Section 8. Force Majeure.** Performance of any obligation under this Agreement may be suspended without liability, but only to the extent that such failure of performance of such obligations is caused by:

- (a) An act of God, riot, accident, fire, explosion, earthquake, flood, failure of transportation, vandalism, strike or other work interruption by workers or any other cause beyond the reasonable control of either party; or
- (b) Any change in the law directly and totally prohibiting this Agreement.

The affected party shall invoke this provision by promptly notifying the other party, in writing, of the nature and estimated duration of the suspension period.

**Section 9. Term.** This Agreement shall commence as of the Effective Date, and shall continue for a period of twelve (12) months. This Agreement shall be renewed by mutual agreement of the parties hereto, confirmed in writing.

**Section 10. Jurisdiction.** The parties hereto agree that all of the provisions of this Agreement and any questions concerning its interpretation and enforcement shall be governed by the laws of the State of Michigan and the parties agree to submit themselves to the venue and jurisdiction of Washtenaw County and jurisdiction of the State Courts of Michigan with respect to any claims arising under this Agreement.

**Section 11. Amendment and Waiver.** No amendment or waiver of any term or condition of this Agreement shall be binding upon either party unless in writing and signed by both parties. No waiver of a breach of a term of this Agreement shall be construed as a waiver of subsequent breach of the same or a different term.

**Section 12. Non-Solicitation Agreement.** During the term of this Agreement and for a period of one (1) year following the termination of the Program, Family agrees that it will not solicit for hire or hire any employees of NAME who have worked with the Program.

**Section 13. Notices.** Any notice hereunder shall be effective in writing and sent by nationally recognized overnight courier at the addresses listed in the opening paragraph and shall be deemed given on the date received.

**Section 14. Entire Agreement.** This Agreement sets forth the entire agreement and understanding of the parties with respect to the subject matter hereof and supersedes all other representations and understandings between the parties.



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**Section 15. Authority.** Family hereby represents that he/she is the lawful parent or legal guardian of the Child with full power and authority to enter into this Agreement on behalf of the Child.

**Section 16. HIPAA Privacy Notice.** Family acknowledges having received, read, understood and accepted the provisions contained in the attached HIPAA Privacy Notice.

**IN WITNESS WHEREOF,** the parties have caused this Agreement to be executed by their authorized representatives as of the Effective Date.

**FAMILY (Parent or Legal Guardian):**

**LEGAL NAME**

By: \_\_\_\_\_

By: \_\_\_\_\_

NAME

\_\_\_\_\_  
(Printed Name)



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**Table A: Finance Worksheet**

This worksheet is to be completed as part of finalizing this contract and can be used as a tool for calculating deposit, monthly payments and total cost of Therapy. First, note the Effective Date of Contract and determine the date of first monthly payment. Next, refer to Table B below to select the appropriate Travel Zone. With this information, you can insert the amount of Travel Fee and calculate the totals. Once you have completed the worksheet, please transfer the totals into section 3 of the contract.

Line	Category	Subtotals	Totals
1	Effective Date of Contract: ____ day of _____, 201__		
2	Deposit for first Therapy Session	\$350.00	
3	Travel Fee in Zone #:		\$
4	Deposit Due on Signing (lines 2 + 3)	\$	
5	Date to begin monthly invoices: _____, 201__		
6	Monthly amount for Therapy	\$350.00	
7	Total Therapy Cost	\$	
8	Total Cost for ____ Therapy Sessions (lines 3 + 7)		\$

**Table B: Travel Fee Table**

Zone	Round-Trip Miles	Cost Per Visit	Travel Fee
1	1-60	NC	NC
2	61-89	\$10.00	\$10 * total # of visits =
3	90-120	\$20.00	\$20 * total # of visits =
4	120+	\$30.00	\$30 * total # of visits =



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**Table C: Payment Form**

Please complete this form by transferring the amounts from “Table A: Financial Worksheet” onto the table below. Next, designate your preferred method of payment for both deposit and monthly payments. Then provide the relevant information below.

Line From Table A	Category	Total Due	Method of Payment	
			Check	Credit Card
4	Deposit Due on Signing	\$		
5	Date to begin monthly invoices: _____, 201__			
6	Monthly amount	\$		

➤ **If you are paying by check or money order:**

- Checks are payable to: “
- Complete the following checklist:
  - ☐ Enclosed is my Deposit, given directly to the PLAY Consultant.
  - ☐ I commit to send the Monthly amount by check to the address below.
- Signed: \_\_\_\_\_ Date \_\_\_\_\_

➤ **If you are paying by credit card:**

- ☐ I authorize BLANK to charge my credit card for the Deposit.
- ☐ I authorize BLANK to charge my credit card for the Monthly amount for \_\_\_\_ months, beginning the month listed in Table C.
- ☐ I authorize the use of the following credit card:

Visa    Master Card    Discover    Card # \_\_\_\_\_

Exp. Date \_\_\_\_\_ Name on Card \_\_\_\_\_

Authorizing Signature \_\_\_\_\_ Date \_\_\_\_\_

Contact phone number: \_\_\_\_\_

CONTACT INFORMATION:            Address



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## Contract Checklist

*Please read and confirm the following statements by checking the boxes below:*

- ☐ I have read the PLAY contract and understand the terms of this agreement.
- ☐ I understand that if I cancel less than 48 hours before a scheduled visit, I will be at risk for a cancellation fee and/or losing that visit
- ☐ I understand and agree to make payments each month beginning the month following the initial deposit until my contract is complete.
- ☐ I understand that if my payment is not made within the calendar month, it will be considered late and services may be discontinued.
- ☐ I have received the HIPAA Privacy Notice.

Signature: \_\_\_\_\_

Please contact your home consultant or with any questions you have related to this contract or the billing schedule.

*Thank you!*

LICENSED PLAY PROJECT PROVIDER ADDRESS AND CONTACT INFO