Name of Client _____ DOB _____

NEW HORIZON
THERAPY

Speech and Occupational Therapy
4700 S Mill Ave #3, Tempe, AZ 85282 | 480-508-7566

Consent for Services

☐ I authorize **New Horizon Therapy** to render appropriate evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time by **New Horizon Therapy** in writing. In addition, **New Horizon Therapy** may terminate services by notifying me in writing.

☐ I do not give my consent or am withdrawing my consent regarding **New Horizon Therapy** rendering evaluation and therapy services to the client named below.

Acknowledgement & Assumption of Risk

☐ I_____ (client or parent/guardian name) understand that I am being asked to carefully reach each of the provisions in this form. I acknowledge and agree to have _____ (client name) receive therapy services from **New Horizon Therapy** and/or any employee or independent contractor employed by **New Horizon Therapy**.

☐ I acknowledge that there is some inherent risks associated with the use of therapy equipment that cannot be eliminated regardless of the care taken to avoid injuries.

☐ I understand the risks and I hereby assert that my participation is voluntary and that I knowingly assume such risks without holding and/or any employee or independent contractor employed by **New Horizon Therapy** accountable for any losses, injuries or other damages occurring to the client and/or myself. I further understand that I am fully responsible for my own safety.

_____ _____ _____

Signature of Client or Legal Representative | Relationship to Client | Date

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Authorization to Exchange, Obtain or Release Information

Client name: _____ Date of Birth: _____

Home Address: _____

For the reasons identified in this form, I _____ (client or family member) hereby grant **New Horizon Therapy** permission to communicate (exchange, obtain, or release) my medical information with the following person or agency:

Name of Person or Agency: _____

Person/Agency Contact Information: _____

Information to Be Released:

- ☐ Medical History
- ☐ Therapy Evaluation
  - ☐SLP ☐OT ☐PT ☐Other:
  - Treatment Notes
    - ☐SLP ☐OT ☐PT ☐Other:
- ☐ School Records (Evaluations, IEP, academic reports, etc.)

For the Purpose Of: (check all that apply)

- ☐ Coordinating care with other professionals
- ☐ Providing continuity of services
- ☐ Updating therapeutic progress
- ☐ Other

☐ I grant permission to exchange information via written and mailed report, phone call, meeting, email, or fax.

☐ I understand that this authorization will remain valid until written revocation of this authorization is presented.

_____ _____ _____

Signature of Client or Legal Representative | Relationship to Client | Date

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HIPAA POLICY A NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
The right to inspect and copy your protected health information.
The right to amend your protected health information.

The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the polices and procedures of our office. We will not retaliate against you for filling a complaint.

Please contact the following for more information:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

General Acknowledgement of Forms

☐ I hereby acknowledge and agree that I read all of the forms and documents provided to me in connection with evaluation and treatment provided by **New Horizon Therapy** and/or their employees.

☐ I fully understand the meaning and intent of the forms provided and I agree to all content included.

☐ I have been given an opportunity to ask questions about the forms provided. All my questions have been answered to my satisfaction by **New Horizon Therapy**

_____	_____	_____
Signature of Client or Legal Representative	Relationship to Client	Date

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Payment Policy

Thank you for choosing our private practice to serve you. We are committed to providing you with the highest quality care. Please know that the timely payment of your bill is an integral part of our service and as such, this payment policy is an agreement between you and **New Horizon Therapy** for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family member. As a client of **New Horizon Therapy** you are required to carefully review and sign our payment policy.

Please read the following information carefully:
All therapy fees (including session fees and/or co-pays, if applicable) are due **at the time of service.**

We accept the following payment methods at this time: All major credit cards and cash.

Payment Arrangements:
New Horizon Therapy Solutions will make a reasonable effort to assist patients in meeting their financial obligations. Financial arrangements for payments will be made at the clinic's discretion, based on the HHS poverty guidelines (http://aspe.hhs.gov/poverty). An application for financial hardship can be completed to determine eligibility for reduced fees.

Please read and check of all boxes to acknowledge understanding and the sign below:
☐ I understand that I am responsible for all costs / fees that any third-party payer (ex. insurance company, private school, etc.) does not cover. In the event that a third-party payer source determines that rendered therapy services are "not covered" or otherwise denied, I will be responsible for all outstanding charges. I understand that I will be billed accordingly and will be responsible for immediate payment. I also understand that **New Horizon Therapy** will not become involved in disputes between you and your third-part source regarding uncovered charges or reasons for denial.

☐ I understand that if fees are not paid in full, treatment sessions may be postponed or cancelled until payment is received.
☐ I understand that I am responsible for all legal and collection fees, which **New Horizon Therapy** may incur if payment is not made in accordance with the terms and conditions herein.
☐ I understand that refunds will be issued only in instances of overpayment. All refunds will be processed within 2 weeks after the overpayment is discovered on the client's bill or at the time the refund is requested. Refunds for payments made with a credit card will be credited back to the credit card used, all other refunds will be issued by a check. Client's who used a third-party source will not be issued a refund until full payment is received from the appropriate source.
☐ I, understand that all cancellations require **24** hours notice and that there will be a **$50** charge for any cancellations made less than **24** hours. This charge is my sole responsibility and will not be covered by a third-party source.
☐ I, _____, (client / guardian name) understand the payment policy and the risks of not adhering to it.

_____ _____ _____
Signature of Client or Legal Representative Relationship to Client Date

OPTIONAL

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Authorization for Credit Card Use

By signing this form you give permission to New Horizon Therapy debit your account for the amount indicated on or after the indicated date. This is permission for current and future services as outlined in this agreement, and does not provide authorization for unrelated debits or credits to your account.

Name on Card: _____

Billing Address: _____

Credit Card Type:
☐Visa ☐Mastercard ☐FSA ☐Discover ☐American Express ☐Other:

Credit Card Number: _____

Expiration Date: _____ Card Identification Number: _____ (3 digits on back of card)

☐ I, _____ (client or parent/guardian name) authorize New Horizon Therapy to charge fees rendered for therapy services to the credit card provided herein.

☐ I understand that the provided credit card will be charged for services rendered (after each session / at the end of the month) and that I will receive a printed invoice as a receipt of payment.

Cardholder, please sign and date:

Print name: _____ Signature: _____

Date: _____

Credit Card Authorization

I authorize New Horizon Therapy to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for therapy services, for the amount invoiced by the practice, and is valid for ongoing monthly and weekly services. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

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Cancellation and Rescheduling Policy

At New Horizon Therapy, we pride ourselves in providing the best therapy for your child. We strive to plan and develop specialized treatment based on your child's need. Due to our treatments being specifically developed to enhance your child's progress, showing late for an appointment as well as not showing greatly impacts our ability to provide the best care that your child deserves.

- In order to provide your child the best care, sessions must start on time. If you arrive late you will only receive the remaining time for that therapy session or you may need to reschedule.
- It is our policy to receive at least **24 hour notice** for all appointment changes or cancellations. Failure to provide our office with adequate notice will result in a $50 charge to your account.
- If more than one appointment in a 4 week period is cancelled **for each** scheduled therapy time without being rescheduled, you may lose your time slot. The staff will examine your situation to determine if New Horizon can continue to provide therapy.
- If a client has 2 or more no shows (not calling the clinic to inform cancelling the session) within a 4 week period, they will receive written notification that services have been discontinued and will be place back on the waitlist.

Please *be courteous to your therapist* and make sure you give ample notice when cancelling. We truly treasure the ability to help your child progress and meet all of his or her goals. Please help us achieve these goals by cooperating with this policy. Feel free to call us at (480) 508 7566 with any questions.

_____	_____	_____
Signature of Client or Legal Representative	Relationship to Client	Date