2022 Patient Information, Therapy Authorization and Release Form

Start of Care: _____

Therapist: _____

Dx: _____

Patient Name: _____

Sex: M F DOB: _____Referring Physician & Ph. #: _____

Patient Address: _____ City, State, Zip: _____

Parents / Caregivers (and relationship): _____ # (_____)_____

Emergency Contact (and relationship): _____ # (_____)_____

Primary Insurance Information – Company (Payer):_____

Policy/ID#: _____ Policy Holder Name: _____

Policy Holder Address:_____ Relationship to Patient: _____

Subscriber DOB: _____ **SS #:** _____ Employer: _____

Secondary Insurance Information – Company (Payer):_____

Policy/ID#:_____ Policy Holder Name: _____

Policy Holder Address: _____Relationship to Patient: _____

Subscriber DOB: _____ **SS #:** _____ Employer: _____

BabyNet: □No □ Yes If Yes, Early Intervention Contact: _____

Known Diagnosis:_____

Medications:_____

Allergies/Reactions:_____

Does your child carry an Epi pen? **Circle: Yes/No**
If yes, please alert our staff and request a Food Allergy Form to be filled out by your child's physician.

Other dietary restrictions:_____

Other precautions/medical equipment: _____

Does your child currently receive OT, PT, or SLP with another provider? Please list frequency and name of provider:
_____

_____ _____

Parent/Guardian Signature & Relationship to Patient Date Witness / Coastal Therapy Services, Inc. Date

Patient Service Agreement & Consent to Treat

Patient's Name: _____ DOB: _____

- It is the parent or guardian's responsibility to **inform Coastal Therapy Services, Inc. of any and all changes in address and insurance information, including group policy number, identification number, phone numbers, addresses, etc.** as soon as possible. This also includes changes in secondary insurance, which may involve Medicaid and/or SC's BabyNet Program. Failure to do so could result in total patient financial responsibility of charges. _____ (please initial)

- For your convenience (for clinic-based appointments only) Coastal Therapy will allow the parent/guardian to leave the premises during their child's appointment, however, it is very important to leave a cell phone number and to return to the waiting room 10-15 minutes prior to the session's end so the therapist may discuss treatment. If our staff notices perpetual tardiness in picking up your child, you will be asked to stay during treatment. _____ (please initial)

- Both private insurers and the Federal Government prohibit waiving and/or reducing deductibles and co-payments. Due to binding contracts with each insurance company and industry-wide standard ethics, **we are required to collect all co-payments and deductibles pursuant to your specific policy at the time of service.**

PAYMENT POLICY & BILLING PROCEDURES

- **Unless 100% coverage has been verified, you are responsible for the percentage and/or deductible not covered by your insurance company.**
- If insurance information is not available or you do not have insurance, payment is due in full at the time of service, unless other arrangements have been made in advance.
- At your request, you may receive receipts and/or a monthly statement that will show you the status of your account.
- There is a $40.00 charge for all returned checks.

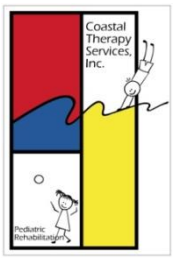
INSURANCE INFORMATION - As a courtesy to our patients, we will verify and file your insurance, to include secondary insurance coverage; however, we cannot guarantee payment. We pride ourselves in assisting you in exploring your insurance benefits so that you may be aware of your out-of-pocket costs prior to initiating treatment; however, it ultimately remains your responsibility to be knowledgeable of your policy's benefits and coverage. We suggest that you read your policy manual as it pertains to therapy coverage. Many insurance companies have stipulations, such as usual and customary fees (UCR), limited therapy sessions, limited reimbursable amounts per session, deductibles, co-payments/co-insurance, etc. Such stipulations should be indicated in your policy manual or available by calling your insurance provider. You are responsible for amounts not covered by your insurance. We have an agreement with you, not your insurance company, for receipt of payment. Please be aware of this and plan to make payments accordingly. By signing below, you acknowledge your financial responsibility, as well as Coastal Therapy Services' right to collect payment for services rendered. This includes the use of collection-based means, and/or small claims court, with all related expenses (including attorney's and agency's fees) in such a case being passed on to you, the client. _____ (please initial)

CONSENT TO TREATMENT - I understand that I have been referred for therapy services and care at Coastal Therapy Services, Inc. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have Coastal Therapy Services, Inc. provide treatment and care as prescribed by my physician and/or recommended by my therapist. _____ (please initial)

I hereby authorize Coastal Therapy Services, Inc. to furnish my insurance company(s) with any information that may be required in order to determine benefits and process claims. I authorize payment of medical benefits to Coastal Therapy Services, Inc. for services rendered to me. ***I understand that I am financially responsible to Coastal Therapy Services for charges not covered by my insurance company.*** I certify by my signature that I have read the above and agree to these policies. In addition, I acknowledge that I have reviewed and understand the updated Clinic Policies and Patient Service Agreement. _____ (please initial)

_____ _____

Parent/Guardian Signature & Relationship to Patient Date Witness / Coastal Therapy Services, Inc. Date



Attendance & Cancellation Policy

We are committed to upholding our reputation for providing exceptional and personalized services to our clients. Therapy will be most beneficial to your child with consistent attendance, which will also ensure compliance with your physician's medical orders. It is important that you arrive on time so your child may benefit from a full session.

If you are not available for a scheduled appointment, please let us know as soon as possible, as we may be able to reschedule to a different day or time.

Cancellations: As a courtesy to our therapists and other clients, please contact us **at least 24 hours prior to your appointment** time to cancel in the case of illness or unavoidable circumstance. Please attempt to reach your therapist directly prior to contacting the office, as all of our therapists manage their own schedules.

We have developed this cancellation policy to:

- Ensure that all of our clients receive effective, timely, and appropriate service
- Protect the time, energies, and availability of our therapists
- Use both the caregiver's and therapist's time most effectively for your child's therapeutic progress

Missed appointments and appointments cancelled in less than 24 hours of scheduled time impact our ability to provide effective therapy services to you and limit the availability of appointments for other clients. A pattern of missed appointments may result in us no longer being able to provide services for your child.

Termination of services will occur following three sessions that were cancelled without appropriate notice, as therapy will no longer be in compliance with physician orders and insurance regulations. Termination of services will also occur if a minimum 75% attendance rate is not maintained over any three month period. A cancellation without notice ("No-Show") may result in immediate discharge from service. This policy is standard within the medical industry.

Additionally, Coastal Therapy Services, Inc. realizes that your time is important and it is our sincere intention to honor all appointment times, be it clinic or natural-environment based. On occasion, a delay or emergency will occur. If this occurs, notification will be given as early as possible. It is our policy that therapists communicate with their clients if they may be more than 5 to 10 minutes delayed. To expedite this process, we ask that the parent/guardian provide us with a daytime phone number for notification purposes.

By signing this form, I agree to cooperate with the cancellation, attendance, and scheduling policy of Coastal Therapy Services, Inc. and its treating therapists.

_____ _____

Signature of Parent or Authorized Person Date

Coastal Therapy Services, Inc. Clinic Policies and Procedures

Patient's Name: _____ DOB: _____

Welcome to Our Clinic!

Thank you for allowing us the opportunity to provide services for your child. Please take the time to make yourself familiar with the following clinic policies, as they require participation on all of our parts to ensure the ongoing safety of you, your child, our staff and facility.

- **All clients and caregivers must stay in the waiting area until their therapist comes for them**. There is no admittance into the treatment areas or administrative offices without therapist or staff accompaniment. If you wait in our waiting area during your child's session or are returning for your child during the last portion of their session, please wait for staff assistance before going into the treatment areas.

- Children may not leave the building without adult accompaniment. Please do not allow your child to play near, with, or open the doors. We want to ensure all children reach their vehicles safely.

- **Socks are required for both children and adults at ALL times in the treatment areas!** Please take the time to assist your child in placing his/her shoes into our shoe cubby prior to the start of the session. Extra socks are available if you need to borrow a pair for the session. Your therapist will let you know if this does not apply to your child.

- If you have other family members with you, please ensure that they are monitored at all times. Our fun, fabulous equipment can actually be quite dangerous without appropriate supervision.

- Please be aware that Coastal Therapy employs video surveillance in our common areas and both video and audio surveillance in our treatment areas. The purpose of this security system is to protect both your child as well as our employees.

- If at any time you would like to contact us, our main line is (843) 216-0290. We value your comments and suggestions and strive to provide you with an exceptional experience, from therapist to administrative staff to our facilities!

- We cannot allow food, drink, or pets in our reception area due to allergy precautions. Thank you for your consideration.

I have read and understand the above policies.

_____ _____

Parent/Guardian Signature Date Witness / Coastal Therapy Services, Inc. Date

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Patient's Name: _____ DOB: _____

Coastal Therapy Services, Inc. will use and disclose your personal health information (PHI) to treat your child, to receive payment for care provided, and for other health care operations, which generally include those activities performed to improve quality of care. A detailed NOTICE OF PRIVACY PRACTICES has been attached to help you better understand the policies regarding personal health information. The terms of notice may change with time and copies of the most current notice are posted and are available in the clinic offices.

By signing below, I testify that I both understand and have either received or been given the opportunity to receive a copy of Coastal Therapy Services, Inc.'s Notice of Privacy Practices, as required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____

Guardian Signature Date

_____ _____

Witness / Coastal Therapy Services, Inc. Date

You are entitled to a copy of this consent after you have signed it. You may refuse to sign this acknowledgement.*

FOR OFFICE USE ONLY

*We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not be obtained because:

- The parent/guardian refused to sign.
- Communication barriers prohibited acknowledgement.
- An emergency situation prevented obtaining acknowledgement.
- Other (please specify) _____

Coastal Therapy Services, Inc.
PO Box 1753
Mount Pleasant, SC 29465
Phone/Fax: (843) 216-0290 / (843) 216-2445
E-mail: Info@coastaltherapyservices.com

Coastal Therapy Services, Inc.

Notice of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your health information. Please review this notice carefully.

A. OUR COMMITMENT TO YOUR PRIVACY:

Our practice is dedicated to maintaining the privacy of your Protected Health Information (PHI). Protected Health Information is defined as individually identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with the notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice of Privacy Practices in our offices in visible locations at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: Ron Thayer at 1127 Queensborough Blvd, Ste 104, Mt. Pleasant, SC 29464 - telephone 843-216-0290

C. WE MAY USE AND DICLOSE YOUR PHI IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. We will use and disclose your PHI to provide, coordinate, or manage your therapeutic care and any related services. Many of the people who work for our practice may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others that may assist in your care, such as your spouse, children, or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits, and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. We may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Healthcare Operations. Our practice may use and disclose, as needed, your PHI to operate our business. These activities include, but are not limited to, evaluation of the quality of care you received from us, training of students, licensing, and to conduct cost-management and business planning activities for our practice. For example, we may disclose your PHI to graduate school students that may work with patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your and/or your child's name. We may also call you by name in the waiting room when your therapist is ready to see you. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of information to family/friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you or your child. For example, a parent or guardian may ask that a babysitter take their child to our office for treatment. In a case such as this, the sitter may have access to this child's PHI.

5. Disclosures Required By Law. Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES:

1. Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury, or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using had been recalled.

2. Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. These situations include, for example: investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute.

E. YOUR RIGHTS REGARDING YOUR PHI:

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. To request a confidential communication, you must make a written request to Ron Thayer (address and phone number listed above) specifying the request. You do not need to give a reason for your request. Our practice will accommodate reasonable requests.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to Ron Thayer (address and phone number listed above). Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure or both; and (c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Ron Thayer (address and phone number listed above) in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

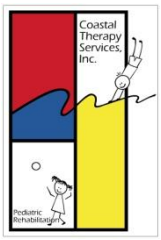
4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Ron Thayer (address and phone number listed above). You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice contact Ron Thayer (address and phone number listed above).

6. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Ron Thayer (address and phone number listed above). All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

7. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note that we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Ron Thayer (address and phone number listed above).



Patient's Name: _____ DOB: _____

Electronic Communication Release

I, _____ (Print), hereby authorize Coastal Therapy Services, Inc. to communicate with me via e-mail and/or text message. This may include photos and/or videos that are helpful and necessary for my child's plan of care.

Email Address: _____

Please indicate any information that you do not want to be communicated via email:

_____

Release for Appointment Reminders

I, _____ (Print), hereby authorize Coastal Therapy Services, Inc. to send me an appointment reminder via text message using the following information.

**Email reminders may contain patient or clinic information such as, but not limited to, patient first name and clinic location.*

Patient / Guardian Contact Information:
(Please print clearly and legibly)

E-mail: _____

Cell phone: _____

Patient / Guardian (Print): _____

Signature: _____

Date: _____

Coastal Therapy Services, Inc. Photo & Video Release Form

I hereby give permission for images of my child, _____ (print name), through video, photo and digital camera, to be used solely for the purposes of Coastal Therapy Services, Inc.'s promotional, marketing, or advertisement materials and publications, and waive any rights of compensation or ownership thereto.

Name of Parent/Guardian (print): _____

Parent/Guardian Signature: _____

Date: _____

Please note this is not a guarantee that any photos will be used in publications and/or marketing materials. Questions may be addressed to Coastal Therapy Services, Inc. at (843) 216-0290.