

Patient Name: _____



CONSENT FOR TREATMENT

I, the undersigned, hereby agree and give my consent to Beyond Therapy to administer such treatment and care as is prescribed and considered therapeutically necessary on the basis of findings during the course of treatment. I also authorize Beyond Therapy to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for the services rendered. The information provided is accurate to the best of my knowledge.

Patient/Authorized Representative Signature Date

Relationship to Patient: _____



Patient Name: _____



CONSENT AND RELEASE TO USE LIKENESS/INFORMATION

(Other than for treatment or payor purposes)

Patient's Name: _____

Date of Birth: _____ MRN: _____

I, or my authorized legal representative, hereby give consent for Beyond Therapy employees or agents to take and use my information and likeness or image as follows including, but not limited to, photographs, videotaped images, audio recordings, digital or other images (Images) for the purposes checked below.

Use ONLY WITHIN Beyond Therapy:

My name, image(s), video, audio, and/or medical information _____ may _____ may not be used for therapeutic and/or educational purposes.

Use OUTSIDE of Beyond Therapy:

I agree to the uses designated below:	My Name	My Image(s)	My Medical Information
☐ For educational purposes outside BT	___ yes ___ no	___ yes ___ no	___ yes ___ no
☐ For marketing purposes	___ yes ___ no	___ yes ___ no	___ yes ___ no
☐ For publication in print or on the internet	___ yes ___ no	___ yes ___ no	___ yes ___ no
☐ Other purpose(s) _____	___ yes ___ no	___ yes ___ no	___ yes ___ no

I understand that BT and its regents, employees, agents, and personnel, acting on behalf of BT, shall not be held responsible for any use of my name and/or image(s), including any use whatsoever by any outside user or third parties, and I hereby release and hold harmless BT and its regents, employees, agents and personnel, acting on its behalf, from any and all liability for damages of whatever kind, character or nature which may at any time result from this release and authorization or from the dissemination of my name and/or image(s) in accordance with this Consent and Release.

I understand that BT will own the image(s) of me, but I have the right to see them or obtain copies of them at a reasonable cost. I do hereby knowingly and voluntarily waive any and all other rights, compensation, royalties, or payment of any kind or character in connection with the use of my name and/or image(s) as authorized above.

This Consent and Release can be revoked or withdrawn at any time, but such withdrawal or revocation must be in writing and sent to the BT Privacy Officer, 411 Summit St., Schulenburg, TX, 78956. Any withdrawal of consent does not affect any information used or disclosed prior to receipt of the written notice of withdrawal.

By signing below, I am indicating that I have read and understand this "Consent and Release to Use Likeness/Information" and that it is binding on my/the patient's heirs, executors and personal representatives. I am 18 years of age or older and am either the patient or have the legal authority to give consent for the patient. This form is **optional** and I understand that I **do not have to sign it** to receive medical care.

Print Name of Patient/Authorized Representative

Signature of Patient/Authorized Representative

Relationship to Patient

Date

Patient Name: _____

Beyond Therapy CLINIC POLICIES

Please read carefully and initial each line item. If you have any questions or concerns, please let us know.

No show and Cancellation Fee Policy: If it is necessary to cancel or change a scheduled appointment for a non-emergent reason, **24-hour advanced notice is required** by calling or texting the provider or office manager.

Emergency and unforeseen circumstances are recognized and understood. Contact the provider or office manager as soon as possible to inform of cancellation due to an emergency.

Initials: _____

Attendance Policy:

To receive the maximum benefit from your therapy, **please arrive on time** for the appointment. Patients who arrive late may not be seen for a full session. **Consistent attendance is also necessary** to reach the desired outcomes outlined in the patient's plan of care. In the case of excessive cancellations (three within 90 days) and/or missing appointments without notification (two within 90 days), the following shall occur:

- The patient and/or responsible party will be notified, and attendance status will be discussed.
- Services and/or appointment schedules may be adjusted or terminated at the discretion of the provider/agency so that we may accommodate other patients awaiting therapy.

***No-show/cancellation reports are reviewed weekly, and the above policies will be enforced this day forward.**

Date: _____ Initials: _____

Financial Policy: A medical insurance policy is a contract between you and your insurance company. Coverage depends upon your insurance company and the specific plan you have chosen. Beyond Therapy is contracted with most insurance companies and as a service to patients we agree to submit your claims directly to them. We carefully review eligibility and benefits based on your insurance coverage prior to initiating services. This is not an agreement of payment from your insurance carrier. **The patient/authorized representative is responsible for all charges not covered by their insurance.** A fee of \$25 will be charged for any check returned by the bank for Non-Sufficient Funds.

***All patient co-payments, deductibles, or private pay fees are due at time of treatment or unless alternate arrangements have been approved by the office manager.**

Initials: _____

Insurance Changes: Changes in healthcare/insurance are very important and need to be discussed with your provider or office manager immediately. Providing the most current insurance information enables us to accurately file claims, maintain authorization requirements, and avoid denials. Please help us keep an open communication about any insurance related changes so that we can avoid any delays in services needed by the patient.

Initials: _____

I understand the policies outlined in this document. I authorize my medical benefits to be paid directly to Beyond Therapy for my services. I acknowledge that I am financially responsible for any balance due on all covered or non-covered services. I authorize the release of any medical or other information necessary to process the claim or provide continuity of care. I consent to receive treatment as prescribed by my provider.

Print Name of Patient/Authorized Representative

Signature of Patient/Authorized Representative

Relationship to Patient

Date

Patient Name: _____



PAYMENT FOR SERVICES AGREEMENT

Services to be Provided

Beyond Therapy will provide therapy services for you or your child (patient) in accordance with the orders provided by the patient's physician. It is understood that licensed therapists employed by Beyond Therapy will complete the services provided. The responsibly party gives permission for the patient to receive therapy services provided by Beyond Therapy

Medicare Patients

If you choose to schedule therapy without a physicians prescription/referral, we MUST obtain a signed therapy plan of care from your physician within 30 days of your initial visit. Also, you must be discharged from any home health care services or agency prior to initiating outpatient therapy. Medicare will not pay for both home health and outpatient care simultaneously.

Insurance Benefits

Beyond Therapy will verify the patient's benefits, file the claims for services provided with the insurance carrier, and notify the responsible party of their financial responsibility. The responsible party understands that the verification of benefits and authorization is not a guarantee of payment and that they are responsible for all charges not paid by the insurance company.

Assignment of Insurance Benefits

The responsible party authorizes any insurance carrier that provides insurance coverage for the patient, to make direct payments to Beyond Therapy for any speech pathology services rendered. The responsible party will accurately inform Beyond Therapy of the patient's insurance coverage and provide information regarding coverage changes within 5 working days of the change.

Release of Information for Reimbursement

The responsible party authorizes the release of information pertaining to the patient's diagnosis and course of treatment to Beyond Therapy by the patient's physician and any other therapy service providers involved in the patient's care. The responsibly party also authorizes the release of information to the patient's physician and any other agencies related to reimbursement issues.

I give permission to Beyond Therapy to release information to my insurance company and bill for services on my behalf. I understand that authorization and verification of benefits is not a guarantee of payment and that I am responsible for any charges not covered by insurance.

I understand the policies as described above. I authorize my medical benefits to be paid directly to Beyond Therapy for my services. I acknowledge that I am financially responsible for any balance due on all covered or non-covered services. I authorize the release of any medical or other information necessary to process the claim or provide continuity of care. I consent to receive treatment as prescribed by my provider.

Patient/Authorized Representative Signature

Date

Relationship to Patient: _____



Patient Name: _____



STUDENT CONSENT

STUDENT AGREEMENT:

Beyond Therapy participates in clinical education programs with area colleges and universities, allowing physical therapy, occupational therapy, and speech-language pathology students to gain tangible experience in their respective field of study. Student clinicians shadow and/or participate in therapy sessions under direct supervision of the assigned licensed therapist. Students adhere strictly to HIPAA privacy practices and uphold the highest standards of professional conduct.

We would like your permission to allow student clinician(s) to participate in your / your child's therapy sessions. Please do not hesitate to ask any questions regarding the clinical education program.

I consent to student participation within the guidelines of the clinical education program described above.

☐ Yes ☐ No

Patient/Authorized Representative Signature Date

Relationship to Patient: _____



Patient Name: _____



Notice of Privacy Practices Acknowledgement

My signature below confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Information Portability and Accountability Act of 1996 (HIPAA). I acknowledge that I have been provided with Beyond Therapy Notice of Privacy Practices that describes how my health information is used and shared. I understand that Beyond Therapy reserves the right to change this notice at any time. I may obtain a current copy by contacting the clinic or the billing office.

Our organization may contact you to remind you of any appointments, health care treatment options, billing concerns, or other health services that may be of interest to you.

May we contact you at home? ☐ Yes ☐ No

Home Phone: _____

May we contact you at work? ☐ Yes ☐ No

Work Phone: _____

May we contact on your cell? ☐ Yes ☐ No

Cell Phone: _____

This authorization will remain in effect until revoked in writing. Copies of your chart or any other written information are not covered by this authorization.

Patient/Authorized Representative Signature

Date

Relationship to Patient: _____





NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and or refuse the release of specific information outside of our system except when the release is required or authorized by law or regulation.

Acknowledgement of Receipt of this Notice

You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgment.

Who Will Follow this Notice

All physicians, licensed health care personnel, employees, staff and other office personnel. Any independent health care professional who may provide services at our office and is authorized to enter information into your medical record. All students or trainees. Any persons or companies with whom Beyond Therapy contracts for services to help operate our practice and who have access to our patients' medical information.

Our Responsibility Regarding Protected Health Information

Your 'protected health information' is individually identifiable health information. This includes demographics such as age, address, email address, and relates to your past, present, or future physical or mental health or condition and related health care services. We are required by law to do the following:

- Make sure that your protected health information is kept private.
- Give you this notice of our legal duties and privacy practices related to the use and disclosures of your protected health information.
- Follow the terms of the notice currently in effect.
- Communicate any changes in the notice to you.

We reserve the right to change this notice. Its effective date is at the top of the first page and at the bottom of the last page. We reserve the right to make the revised or changed notice effective for health information we already have about you or your child as well as any information we receive in the future. You may obtain a Notice of Privacy Practices by calling the phone number at the top of this notice.

Our System

Beyond Therapy works with several agencies and referral sources. Your health information will be shared in the following manner:

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes disclosure to your physician or other health care providers who becomes involved in your care.

- Within our office for administrative activities, quality assessment, oversight and peer review.
- With our billing personnel and as necessary to obtain payment for your health care services.
- With your insurance company or other payers as required for payment.
- With the referring agency and case manager.
- With any other provider, school and/or agency with your written request.

You may request written or verbal information sharing in writing. Your request should include a specified period of time for information sharing.



Patient Name: _____

Required by Law

We may use or disclose your protected health information if law or regulation requires the use or disclosure. We will notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

Health Oversight

We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These health oversight agencies might include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

Legal Proceedings

We may disclose protected health information during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such a disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Parental Access

We may disclose your protected information to parents, guardians and persons acting in similar legal status.

For Health Care Operations

Beyond Therapy, staff and business associates may use and disclose medical information about you to operate this office. For example, Beyond Therapy may use medical information to call out your name in the waiting room, to review treatment and services or to evaluate the qualifications and performance of therapists in caring for you. Beyond Therapy, may also disclose information to licensing authorities or offices who evaluate qualifications and review care to determine if Beyond Therapy and its therapists can be licensed, credentialed, certified or approved under a health plan or to treat patients at a particular facility. Beyond Therapy, may contract with other professionals or companies, such as medical record transcription services, consultants, financial advisors or legal counsel, to help us run the practice and who have agreed to follow our Notice of Privacy Practices.

Contacting You

Unless Beyond Therapy has agreed in writing to your written request to handle these matters differently, Beyond Therapy may use and disclose medical information to leave you a message or send you a letter concerning an appointment or to ask you to call concerning your care or your account. Beyond Therapy will use the contact information that you provide.

Individuals Involved in Your Care

Beyond Therapy may disclose medical information about you or your child to a friend or family member who is involved in your medical care, unless you object. You can object to these disclosures by notifying Beyond Therapy in writing that you do not wish any or all individuals involved in your care to receive this information. If you are not present or cannot agree or object, Beyond Therapy will use our professional judgment to decide whether it is in your best interest to disclose relevant information to someone who is involved in your care.

Research

Under certain circumstances, Beyond Therapy may use and disclose medical information about you or your child for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received treatment to those who received another for the same condition. Beyond Therapy will obtain your written consent if the researchers will know who you or your child is. Medical information about your child that has had all identifying information removed may be used for research without your consent.

Uses and Disclosures of Protected Health Information Requiring Your Permission

In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. Since some of our therapies are provided in your home or other natural environments, those present during the session, including friends, family, or day care providers may hear health information regarding you or your child. Please notify our office in writing if you do not want your protected health information to be discussed with those present during the session. If you or your child receives therapy at our office the therapist may discretely share your progress in the waiting room in front of other patients. If you do not wish to have your progress shared in the waiting room, please notify our office in writing.



Patient Name: _____

Your Rights Regarding Your Health Information

You may exercise the following rights by submitting a written request to the Beyond Therapy office.

- You may inspect and obtain a copy of your protected health information that we keep as a part of medical and billing records.
- You may ask us not to use or disclose any part of your health information for treatment, payment, or health care operations.
- Your request must be made in writing. This request will be honored if we mutually agree that the restriction will not harm you or your child.
- You may request that we communicate with you using alternative means or at an alternative location. We will not ask you the reason for your request.

We will accommodate reasonable requests, when possible.

If you believe that the information we have about you or your child is incorrect or incomplete, you may request an amendment to your protected health information as long as we are responsible for and maintain this information.

Federal Privacy Laws

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). There are several other privacy laws that also apply including the Freedom of Information Act and the Privacy Act. These laws have been taken into consideration in developing our policies and this notice of how we will use and disclose your protected information.

Changes to the Notice of Privacy Practices

Beyond Therapy reserves the right to change this notice. Beyond Therapy reserves the right to make the revised or changed notice effective for medical information already held about you as well as any information received in the future. Beyond Therapy will post a copy of the current notice in the office. The notice will remain in effect for each subsequent visit unless changed. If the notice changes, a copy will be available to you upon request.

Questions and Complaints

If you have any questions about this notice, please contact the Privacy Officer at (979) 743-2108. To notify our office in writing of a request please mail to the following: Privacy Officer, Beyond Therapy, 411 Summit Street, Schulenburg TX, 78956-1532. If you have a complaint about your privacy rights, you may file a written complaint with this office or with the Secretary of the United States Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer at (979) 743-2108. You will not be penalized for filing a complaint.

Patient/Authorized Representative Signature

Date

Relationship to Patient: _____

