**NOTICE OF INFORMATION PRACTICES AND PRIVACY STATEMENT**

PerdueWorks Therapy Group collects data through a variety of means including, but not limited to letters, phone calls, emails, voicemails, and from the submission of applications that are either required by law, or necessary to process applications or other requests for assistance through our organization. Information about client financial situations, medical conditions and care that is provided to the company in writing, via email, on the phone (including information left on voicemails), contained in or attached to applications, or directly or indirectly given to PerdueWorks Therapy Group is held in strict confidence. PerdueWorks Therapy Group does not give out, exchange, barter, rent, sell, lend, or disseminate any information about the clients who apply for or receive services that are considered client confidential, restricted by law, or has been specifically restricted by a signed HIPAA consent form.

Information is only used as is reasonably necessary to process applications or to provide therapy services which may require communication between PerdueWorks Therapy Group and health care providers, medical products or service providers, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services needed including, but not limited to; or to obtain or purchase any type of devices. PerdueWorks Therapy Group may send reminders for therapy via email or voicemail. Clients may specifically request that NO information be used or given to certain providers, for reminders, etc., but the client or guardian must identify any requested restrictions in writing.

If the client provided information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Any pictures, stories, letters, correspondence, or thank you notes sent to PerdueWorks Therapy Group becomes the exclusive property of PerdueWorks Therapy Group. PerdueWorks Therapy Group reserves the right to use non-identifying information about our clients for promotional purposes that directly relates to the company's mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without the client’s express advance permission.

Clients may specifically request that NO information be used whatsoever for promotional purposes, but the client or guardian must identify any requested restrictions in writing. PerdueWorks Therapy Group respects the right to privacy and assures clients that no identifying information or photos will ever be used without direct written consent.

**CONSENT & ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**

I understand that as part of the provision of healthcare services. PerdueWorks Therapy Group creates and maintains health records and other information including, but not limited to, mine or my child's health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment I have been provided a copy of the Notice of Privacy Practices that provides a complete description of the uses and disclosures of certain health information. Prior to signing this consent, I reviewed the Notice of Privacy Practices. I understand that the organization reserves the right to change the Notice and Practices prior to implementation and will make me aware of any changes by updating the website and other social media I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting, or arranging for medical review, legal services, and auditing functions, etc.) and the organization is not required to agree to the restrictions requested. By signing this form, I consent to the use and disclosure of protected health information about me or my child for the purposes of treatment, payment, and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already been in reliance on my prior consent.

**This consent is given freely with the understanding that:**

Any and all records, whether written or oral or in ·electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except otherwise provided by law. A photocopy or fax of this consent is as valid as the original. I have the right to request that the use of my Protected Health Information which is used or disclosed for the purposes of treatment, payment, or healthcare operations be restricted. I also understand that the Practice and I must agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information, which have been previously agreed upon.

I understand that if permission is given for email, that is how appointment reminders will be sent.

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of Parent/Legal Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client or Parent/Legal Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature to consent to email notifications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General billing policy and fee for service policy:**

The billing process can sometimes be complicated. We want our billing services to be as easy as possible so we would like to prepare you for what to expect. Please review this information and sign where indicated. Billing Process Prior to the first visit, PerdueWorks Therapy Group will verify eligibility and benefits. This is a courtesy service and the information collected is only an estimate and is only as accurate as what the insurance company has on file at the time. It is ultimately the patient’s responsibility to provide the correct insurance information to file claims. Claims not paid due to incorrect information will then become patients’ responsibility. All copays and coinsurance amounts are based on the treatment received.

* I understand that THE FEE I AM QUOTED IS AN ESTIMATE based on (1) anticipated visits to be performed and (2) current information provided to the clinic by my insurance carrier. At each visit, PerdueWorks Therapy Group may collect a copay, coinsurance, or deductible payment, as pre-arranged based upon your individual insurance plan terms. Claims will then be sent to your insurance company which can usually take 30-45 days for the claim to be processed. PerdueWorks Therapy Group will send a statement if there are charges remaining that you may owe after

insurance payment. If you did not follow your insurance plan’s terms, they may not pay for all or part of your care. We will contact you if your insurance company does not pay your claims in a timely manner.

* I understand that PerdueWorks Therapy Group will collect payment before every scheduled treatment session and has the right to refuse services if payment cannot be rendered.
* I understand that it is my responsibility to provide PerdueWorks Therapy Group with current accurate billing information at the time of check in and to notify the clinic of any changes in this information immediately.
* I understand that it is my responsibility to know my co-insurance and or copay for therapy services, which can be different from my primary care co-payment, and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan; PerdueWorks Therapy Group also has a contractual agreement with my health plan to collect co-insurances, co-pays, and deductibles at time of service. I understand I will be billed for any amounts owed by me and that I have a financial responsibility to pay the amounts owed. I understand that I will receive a statement by mail or by email and will need to pay by the due date listed. I understand that what my insurance company does not pay for within 120 days of treatment I will be responsible for the remaining billed amount. I understand that if payment is not received a “Final Notice” will be sent and the final step will be the account being sent to an outside collection agency. If I do not pay my patient balances, PerdueWorks Therapy Group is required to report this to the insurance carrier.
* I understand that if I present an insufficient funds check (NSF Check) for payment on my account that I will be charged a $35 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, check, or credit card and must pay the NSF Fee before the next scheduled appointment.
* Prior authorizations are often required before certain services are rendered. Most insurance companies will not give a retrospective authorization, hence the use of the term “prior authorization”. I understand that the clinic will obtain the necessary prior authorizations before rendering treatment. If a prior authorization is not obtained because I neglected to inform PerdueWorks Therapy Group of a change of insurance in a timely manner, I will be billed for any/all uncovered services. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier. I understand that my services may be put on hold until a new prior authorization has been obtained.

My signature below confirms that I have read these billing policies, and my financial obligation as pertains to the providers of PerdueWorks Therapy Group.

Patient name printed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By completing the section below, I understand my card will be charged in the event the patient incurs a balance. The card will only be charged if there is a balance due, but you will be contacted prior to the transaction being done.

Credit Card Information:

Credit Card Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CVV Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name on Card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Comprehensive Treatment Plan Agreement:**

The following is a description of this clinic's policies regarding the comprehensive treatment plan. Please read and indicate your agreement to abide by these policies by initialing and signing/initialing where indicated. If you have any questions about these policies, please ask a representative of this clinic before signing.

**Consent to Treat**: Initials\_\_\_\_\_\_\_I, the Client/Parent or Legal Guardian hereby consent to treatment for therapy services. I further understand that the plan for treatment is recommended by the doctor primarily responsible for my or my child's care. I understand that I may be seen for treatment by a licensed therapist or therapist's assistant and in order to receive maximal benefit from treatment, it is important for treatment to occur each week, on a consistent basis. I have read and agree to the above policies.

**Non-Discrimination Policy:** Initials\_\_\_\_\_\_ The center does not discriminate against any person on the basis of race, color, national origin, disability, age in admissions, treatment, participation in its programs, services and activities, or in employment.

**Office Policy for Families with Child Clients**: Initials\_\_\_\_\_\_ I understand that I should demonstrate behavior that shows respect and consideration for others within the clinic. PerdueWorks Therapy Group understands that infants and toddlers often need to be accompanied by a parent during treatment; all other individuals are asked to please wait in the waiting area during treatment sessions. I also understand that I am responsible for waiting with my child in the waiting room until the treatment session begins and for monitoring my child’s play in the waiting room. I understand that the clinic prefers I wait during the session so that I am able to monitor some of my child’s treatment when appropriate. I understand that it is the policy of this clinic that a parent or legal guardian must remain in the clinic during treatment sessions.

**Acknowledgement of Risk**: Initials\_\_\_\_I understand that there is some risk inherent in the use of therapeutic equipment at this clinic, and I agree to indemnify and hold the clinic harmless for any and all losses and claims for any injuries occurring to my child or myself from the use of therapeutic equipment. Furthermore, I understand that the clinic is not responsible for personal belongings left unattended during therapy sessions.

**Coordination of Care:** Initials\_\_\_\_\_I give permission to have this clinic contact and discuss my child’s/my case with all persons whose names I have provided as professionals working with my child or myself. I also give permission for this clinic to send copies of progress reports to all referral sources whose names I have provided. I, to the best of my knowledge, have provided the clinic with an accurate and complete medical history about present complaints, past illnesses, hospitalizations, surgeries, medications, existence of advanced directives and other pertinent data. I will agree to notify the clinic of any changes in my or my child’s condition or circumstances.

**Consent to Photograph and/or Video**:\_\_\_\_\_\_\_ PerdueWorks Therapy Group will occasionally take pictures or videos of clients in therapy. They may be used for promotional purposes such as our website, social media and brochures, etc. I give permission for photography/videotaping to be taken of myself or my child for educational and/or promotional purposes. If I object to pictures or video being published as previously stated, I will NOT initial this section.

**Scheduling Policy:** Initials\_\_\_\_\_\_In order for therapy interventions to be successful, the client must be committed to following the treatment plan of care recommended by the doctor and therapist.

Consistent attendance is key to your success in therapy. Consistent attendance in therapy sessions allows routine practice of skills, as well as faster progress towards therapy goals. When treatment is not consistently attended, progress slows and the

possibility of regression increases. Considering these factors, the following policies have been identified to encourage client success.

Clients will attend all scheduled therapy treatment sessions (SEE ATTENDANCE AND CANCELLATION POLICY). In the event an appointment must be cancelled, a make-up session may occur with a substitute therapist if the client’s regular therapist is unavailable. If a client is arriving late for a scheduled treatment session, contact must be made with the clinic. The clinic will attempt to accommodate the client, however if too much time has passed, the session will be considered a no show and will need to be made-up on an alternate day and time.

Once a weekly treatment appointment schedule has been determined, the clinic is often unable to accommodate changes for temporary periods of time. When a permanent change in time is needed, the client must give as much advance notice as possible for the clinic to attempt to accommodate this request. A change in time may necessitate a change in therapist as well.

Notification of vacations or other obligations is requested at least two weeks prior to the expected absence, to facilitate rescheduling appointment(s). Make up sessions for vacation time will be made-up two weeks before or after, following the vacation time period.

If a therapist is ill or on vacation, the clinic will make every effort to provide a substitute therapist to ensure continuation of services.

For children under the age of 5 years of age, the clinic requires them to be scheduled for therapy appointments before 3:00pm. An exception will be considered if there is a school aged sibling attending therapy after 3:00pm.

I have read and agree to abide by the above policies:

Printed Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of Parent/Legal Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client or Parent/Legal Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Bad Weather Days:**

From time to time the clinic may be required to close due to severe weather conditions. Clinic closings due to bad weather will be posted on our website as well as our social media pages: Facebook and our Website. The clinic will also attempt to call all clients affected by the closure to reschedule their appointments.

**Fees:** Any services such as phone call request to discuss treatment or progress, assessment letters, school letters, psychological letters, extended visit session, court appearances, etc., constitute additional charges. This fee payment will be required prior to completion of request. The fee range for the above items, will range from $65.00 to $1,500.00.

My signature below indicates that I have read the above policy and understand and accept the terms and conditions. I understand that in the event I do not comply with the doctor’s recommended plan of care, the clinic is obligated to inform my referring physician with an explanation as to why it has not been able to obtain frequency compliance. I accept the consequences if I refuse treatment or if I do not follow or understand the instructions given to me or my child by the health care team member.

**Attendance and Cancellation Policy:**

PerdueWorks Therapy Group is pleased to offer high quality therapy services. Every attempt is made to schedule services in a timely manner and when possible, at your convenience. Regular attendance is important to achieve progress and success in therapy and it is necessary that all appointments be kept whenever possible. Because of the demand for therapy services and to ensure positive outcomes, we must enforce the following attendance policy:

**Attendance and Cancellation Policy:**

Therapy services will not be effective unless you are consistent with attending scheduled appointments. If two appointments within a four-week period are missed, due to either cancellation or no show, and NOT rescheduled, a discharge from therapy services may be indicated. If you are unable to keep your scheduled appointment, you must provide 24-hour notice that you will be unable to attend the scheduled appointment. A fee of $50.00 will be charged to you when the policy is not followed.

**Cancellation due to Illness-Communicable Disease Policy:**

It is the policy of the Clinic that in the event a client becomes ill, the center will utilize the following guidelines for re-admitting clients into treatments as listed below:

**Cancel appointment if one or more of these conditions are present**:

-Temperature of 100 degrees or above

-Vomiting, nausea, or severe abdominal pain

-Sore throat, acute cold, or persistent cough

-Red, inflamed, or discharging eyes

-Acute skin rashes or eruptions

-Other symptoms suggestive of acute illness

**Return to Therapy Guidelines:**

-Fever free for 24 hours

-Symptom free of vomiting, nausea, or severe abdominal pain

-Symptom free of sore throat, acute cold, or persistent cough

-Symptom free diarrhea: runny, watery, or bloody

All health conditions listed above have been treated and resolved. I agree to call and reschedule mine or my child’s appointment after the illness has been treated and resolved. Upon the therapist’s judgment, your child might be referred to the PCP.

**Court Testimony Agreement and Information**

Should you involve PerdueWorks Therapy Group or a representative in legal or court related processes or subpoena as a factual case witness, you agree to pay **$1,500.00** which includes a **$500** non-refundable deposit. Fees for court related services are **$250.00** for every hour of the therapists’ time involved, including but not limited to phone consultation with client or client’s attorney about court hearing, drive time, wait time, court testimony, deposition, paperwork preparation and any other legal matters. If you or an opposing party choose to have me subpoenaed with or without my approval, the above charges will apply.

**Initial one of the following statements:**

­\_\_\_\_\_\_\_\_ I AM seeking therapy or counseling for court testimony or court involvement.

\_\_\_\_\_\_\_\_ I AM NOT seeking therapy or counseling for court testimony or court involvement.

\_\_\_\_\_\_\_\_ I AM seeking therapy or counseling to obtain disability through my insurance.

By signing this form, you are acknowledging that you have let the therapist know if there will be court or court related purposes/motivations or under the advisement of an attorney. This includes if you have hired an attorney or are involved in any child custody or visitation issues. Your signature below indicates that you have read and understand this document and any questions you had about this document were answered to your satisfaction. You agree to waive your therapist’s involvement in any legal matters that are deemed not appropriate for their participation.

Printed name of patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_