Therapeutic Potentials, Inc.

Patient Information

PATIENT: _____

DOB:_____ GENDER: MALE FEMALE

ADDRESS: _____ CITY/STATE/ZIP: _____

CELL PHONE: _____

RESPONSIBLE PARTY: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

EMAIL: _____

EMERGENCY CONTACT PERSON: _____

RELATIONSHIP:_____CELL PHONE: _____

REFERRING PHYSICIAN: _____

ADDRESS: _____CITY/STATE/ZIP:_____

PHONE: _____ FAX: _____

PRMIARY INSURANCE INFORMATION

PRIMARY INSURED: _____ DOB: _____

INSURANCE COMPANY: _____ PH#: _____

ID NUMBER: _____ GROUP#: _____

EMPLOYER: _____

SECONDARY INSURANCE INFORMATION

PRIMARY INSURED: _____ DOB: _____

INSURANCE COMPANY: _____ PH#: _____

ID NUMBER: _____ GROUP#: _____

EMPLOYER: _____

Please Attach a Copy of Insurance Card Front and Back

Financial & Office Policy

Patient Name:_____**DOB:**_____

This Financial Policy will explain our billing policy and expectations. Please read it carefully. A copy will be provided upon request and a copy is kept with your billing records.

Payment is expected at the time of services are rendered. I understand that I am responsible for all deductibles, coinsurance, copayments, and/or non-covered services. A claim for services will be filed to the insurance company as a courtesy, however, all follow-up of unpaid claims will be my responsibility.

Assignment of Benefits:

I hereby authorize Therapeutic Potentials, Inc, to release information acquired, during the course of my examination and treatment, to Medicare, Medicaid, Medigap, and/or commercial insurance carriers, as necessary, to secure payment of any benefits due.

I hereby assign payment of benefits directly to Therapeutic Potentials, Inc, for any medical treatment performed and billed to Medicare, Medicaid, Medigap, and/or commercial insurance carriers. I understand that I am responsible for all charges regardless of insurance status as well as any associated costs for collection should such action become necessary. I agree that this authorization shall be valid until rescinded in writing or replaced on a future date. A photocopy of this agreement shall be considered as valid as the original. I have read and fully understand the terms above.

Balances remaining unpaid over 30 days may accrue interest in the amount of 1.5% of my balance each month (18% APR) and may be turned over to an outside agency for collection. I agree(s) that in the event of default or that the account is placed with a collection agency for collection, I am responsible for reasonable attorney's fees, collection agency fees, court costs, service charges, and/or interest as allowed by the law. In the case that legal action is instituted to collect such fees due to failure to pay on my part, I agree to pay in addition to the costs and disbursements provided by statute such sum as the court may adjudge reasonable as attorney's fees in said action. In a divorce situation, as a parent, I am responsible for all charges incurred. Although a divorce decree may state that an ex-spouse is responsible for medical bills, Therapeutic Potentials, Inc,. has no authority to enforce compliance with such a decree and requires payment in accordance with this policy. Information about my account maya be reported to credit bureaus. Late payments, missed payments, or other defaults on my account may be reflected in my credit report.

Therapeutic Potentials, Inc., reserves the right to discontinue all therapy services until delinquent accounts are satisfied.

Brief conferences as well as brief telephone conferences are considered part of the regular intervention program, and no additional charges will be made. There will be a charge for conferences with parents, physicians, tutors, or teachers that exceed 10 minutes in length.

If I must cancel a scheduled appointment, it is necessary that I give 24 hour advance notice. Except in the case of emergency or sudden illness, with the exception of Medicaid clients, appointments that are not cancelled with a 24 hour advance notice will be charged as if session was held. Medicaid patients who miss three scheduled appointments without a 24 hour advance notice (except in cases of emergency or sudden illness) will become ineligible to receive further services from Therapeutic Potentials, Inc. I understantd that at various times of the year, my child's therapist may be away from the office. I will be notified in advance of the dates and a makeup session will be scheduled or a substitute therapist will be offered.

Returned check policy: A $50.00 fee will be charged to your account for all returned checks.

I have read and accept the above policies and authorize Therapeutic Potentials, Inc., to provide evaluation and therapeutic services for my child.

_____

Name (Client, parent, guardian, responsible party) *Please print* **Relationship**

_____

Signature (Client, parent, guardian, responsible party) **Date**

Consent to Treatment Form

Patient Name:_____ **DOB**: _____

CONSENT TO MEDICAL TREATMENT:

I, the undersigned, whether acting as parent, guardian, responsible party, or agent, voluntarily consent to therapy as determined to be necessary or beneficial in the professional judgment of my physician or therapist that falls within the scope of practice as defined by the State of Florida.

I acknowledge that no guarantees have been made to me as to the effect of such treatment on the patient's condition.

By signing this form, I acknowledge that I have read and understand the contents and that I am authorized to execute it on behalf of the patient.

_____

Name (Client, parent, guardian, responsible party) *Please print* **Relationship**

_____

Signature (Client, parent, guardian, responsible party) **Date**

Therapeutic Potentials Inc.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOR MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect __4/14/2003____, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy or our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURE OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at anytime. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights Section of the notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved With Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses of disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up therapeutic tools or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter intelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail)), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns please contact us.

If you are concerned that we may have violated your privacy rights, or your disagree with a decision we made about access to your health information or in response to a request your made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of you health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Ray Colombo

Telephone: 941-758-3140 Fax: 941-870-4891

E-mail: RColombo@TPIKids.com

Address: 6977 Professional Parkway East Sarasota, FL 34240

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement

I _____ , have received a copy of this office's notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____
_____
_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name:_____**DOB**:_____

*You May Refuse to Sign This Acknowledgement

I _____ have received a copy of this office's notice of Privacy Practices.

I authorize Therapeutic Potentials, Inc., to share Protected Health Information with the following person(s):

_____Relationship_____

_____Relationship_____

May we leave appointment information on your answering machine? YES NO

May we leave medical or billing information on your answering machine? YES NO

May we text appointment information to your cell phone? YES NO

May we email you appointment or billing information? YES NO

_____

Name (Client, parent, guardian, responsible party) *Please print* **Relationship**

_____

Signature (Client, parent, guardian, responsible party) **Date**

For Office Use Only

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

_____Individual refused to sign

_____Communication barriers prohibited obtaining the acknowledgement

_____An emergency situation prevented us from obtaining acknowledgement (Specify)

_____

_____

Staff Signature **Date**

Release of Personal Health Information

Patient Name:_____**DOB**:_____

I,_____, authorize Therapeutic Potentials, Inc. to Release Personal Health information to the following professionals:

Please print names and phone numbers:

Educators_____

Caregivers_____

Physicians_____

Speech Language Pathologist_____

Occupational Therapist_____

Physical Therapist_____

Psychologists_____

Other_____

Other_____

Other_____

_____

Name (Client, parent, guardian, responsible party) *Please print* **Relationship**

_____ _____

Signature (Client, parent, guardian, responsible party) **Date**