Whole Team Therapy
1200 River Ave, Suite 10C
Lakewood, NJ 08701
Tel 732-534-6707 Fax 732-534-6703
www.wholeteamtherapy.com

Today's Date: _____/_____/_____

Patient Name: _____ Date of Birth: _____

Home Address:_____

City: _____ State: _____ Zip: _____

Phone (home):_____ (cell): _____

Email Address: _____

If you are filling out this form for a minor/dependent, please enter:

Your Name: _____ Relationship to patient: _____

Other Parent / Guardian Name: _____ Email Address: _____

Other Parent / Guardian Cell Number: _____

Please circle one**:** I **do / do not** wish to correspond through email.

Please circle one: I **do / do not** wish for voice messages to be left on my home phone.

Can we send reminder texts to your cell phone to confirm appointments? **Yes** **No**

Mobile provider: _____ Message and data rates may apply

Emergency Contact:

Name: _____

Phone: _____ Relationship: _____

Who referred you to Whole Team? _____

Insurance Information:

Subscriber Name (if different than patient): _____

Subscriber Date of Birth: _____ Subscriber Relation to Patient: _____

Insurance Company: _____ Insurance Phone #: _____

ID Number: _____ Group Number: _____

AUTHORIZATION AND CONSENT

Above Information: I, the undersigned, do hereby certify that I have understood and completed the above information and know it to be truthful and accurate to the best of my knowledge.

Authorization for Treatment: I, the undersigned, am seeking treatment for myself or for an individual for whom I am a guardian, for condition(s) requiring medical therapy services. I hereby voluntarily consent to such treatment and procedures to be performed by Whole Team Therapy personnel.

Privacy: I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Whole Team Therapy ("The Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary to carry out any healthcare operations that are permitted in the regulations. I am aware that The Practice maintains a "Privacy Notice" which sets forth the types of uses and disclosures that The Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which The Practice will make such use or disclosure. By signing this consent, I understand and acknowledge that I have reviewed the "Privacy Notice".

Information Release: If you would like The Practice to disclose your / your child's information with other people (that are not guardians), please request and fill out Whole Team Therapy's authorization form.

Assignment of Benefits: I hereby assign all medical benefits to include Major Medical, Medicare, Private Insurance and other sponsored programs and health plans and I authorize payment of medical benefits to Whole Team Therapy. I understand that I am financially responsible for all charges whether paid by said insurance and I hereby authorize said assignee to release all information necessary to secure payment of said benefits. The assignment will remain in effect until revoked by me in writing.

Medicare Lifetime Signature on File: I request the payment of authorized Medicare benefits be made on my behalf to Whole Team Therapy for any services furnished to me. I authorize any holder of medical information about me to release any information to determine the benefits payable for related services. This information will be used for evaluating and administering claims of benefits.

Permission to take Photograph: I hereby consent for Whole Team Therapy to take a photograph of me only for the purpose to use in my medical chart, and will not be disclosed for any other reason, without additional permission from me.

_____ _____

Signature (Patient / Parent / Legal Guardian) Date

If you are filling out this form for a minor for Physical or Occupational Therapy:

A parent / legal guardian must be present with a minor patient (under 18 years of age) for the Initial Evaluation visit. Other PT/OT visits are allowed without a parent / legal guardian ONLY with a signed authorization.

☐ I give my permission as the legal guardian for _____ date of birth _____ to be seen in your office without the presence of myself or another adult for Physical/Occupational therapy visits.

_____

Signature (Parent / Legal Guardian)

SCHEDULING AND PAYMENT POLICIES

SCHEDULING

At Whole Team Therapy, we strive to provide excellent care with treatment provided on a one- on- one basis by your therapist. The appointments you make will be reserved specifically for you. To receive the maximum benefit of treatment, it is important that you attend each of your scheduled appointments and that you arrive on time for your appointments.

Providing one-on-one care to each client requires that we do not overbook or double book our appointments. As such, missed appointments result in unused time in our therapists' schedules and are a lost opportunity for them to help other clients, as well as a financial loss to Whole Team. **Therefore, we have a 24 business hour cancellation / rescheduling policy. If you miss or cancel your appointment with less than 24 business hours' notice, you will be charged a $100 cancellation fee, unless it was/is a documented medical emergency.**

In addition, you are entitled to cancel up to 3 scheduled appointments - *with 24 business hours' notice* - per school year. Once these 3 allowed cancellations have been exhausted, a $50 cancellation fee will be charged for cancelled sessions. This policy is in place out of respect for our therapists and our other clients who are waiting for appointments. These fees are your responsibility and must be paid prior to your next scheduled treatment.

PAYMENT

As a courtesy, we will try to verify your benefits prior to your first visit. However, experience has taught us that we can be given incorrect information. We strongly suggest that you personally contact your insurance company for verification of benefits.

- Co-pays, co-insurances, and deductibles are dictated by your insurance company. We are legally required to collect these charges, and they are due prior to the beginning of each treatment session.
- If you have a plan with a co-insurance, we will estimate your expected co-insurance and require that it be paid prior to the beginning of each treatment session. If you have a deductible that has not been met prior to treatment, you will be required to make a payment towards the deductible at each visit.
- **If your insurance company does not pay, or their payment does not meet our minimum rate, you are responsible for the balance.**
- Payment can be made by credit card, check or cash. We require a credit card be kept on file so that we can collect past due balances. We will attempt to contact you prior to charging your card.
- Medicare clients: We will submit claims to Medicare. You will be responsible for the deductible and coinsurance, which can be billed to secondary insurance, if applicable.

If you have any additional questions, please do not hesitate to ask us.

I have read and understood the above policies.

_____ _____

Signature Date

CREDIT CARD AUTHORIZATION

At Whole Team Therapy, we require keeping your credit card on file as a method of payment for outstanding balances, and/or to cover the portion of services that your insurance company does not cover, but for which you are liable.

Your credit card information is kept confidential and secure. We will attempt to contact you before charging your card.

I authorize Whole Team Therapy to charge the portion of my bill that is my financial responsibility, to the following credit or debit card:

☐ Amex ☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number _____

Expiration Date _____ / _____ / _____ CVV#_____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ State_____ Zip _____

I, the undersigned, authorize Whole Team Therapy to charge my credit card, indicated above, for balances due for services rendered.

Name (Print): _____

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES – WHOLE TEAM THERAPY

Effective 08/01/2017

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.

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability & 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 amend your protected health information. You have the right to approve or refuse the release of specific information outside of our Practice except when the release is required or authorized by law or regulation.

ACKNOWLEDGMENT 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. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information in accordance with law.

OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION – "Protected health information" is individually identifiable health information and includes demographic information (for example, age, address, etc.), and relates to your past, present or future physical or mental health or condition and related health care services. Our Practice is required by law to do the following: (1) keep your protected health information private; (2) present to you this Notice of our legal duties and privacy practices related to the use and disclosure of your protected health information; (3) follow the terms of the Notice currently in effect; and (4) post and make available to you any revised Notice. We reserve the right to revise this Notice and to make the revised Notice effective for health information we already have about you as well as any information we receive in the future. The Notice's effective date is at the top of the first page and at the bottom of the last page.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION – Following are examples of permitted uses and disclosures of your protected health information. These examples are not exhaustive.

Required Uses and Disclosures – By law, we must disclose your health information to you unless it has been determined by a health care professional that it would be harmful to you. Even in such cases, we may disclose a summary of your health information to certain of your authorized representatives specified by you or by law. We must also disclose health information to the Secretary of the U.S. Department of Health and Human Services (HHS) for investigations or determinations of our compliance with laws on the protection of your health information.

Treatment – We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we may disclose your protected health information from time-to-time to another physician or health care provider (for example, a specialist, pharmacist or laboratory) who, at the request of your physician, becomes involved in your care. In emergencies, we will use and disclose your protected health information to provide the treatment you require.

Payment – Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities we may need to undertake before your health care insurer approves or pays for the health care services recommended for you, such as determining eligibility or coverage for benefits. For example, obtaining approval for a procedure might require that your relevant protected health information be disclosed to obtain approval to perform the procedure at a particular facility. We will continue to request your authorization to share your protected health information with your health insurer or third-party payer.

Health Care Operations – We may use or disclose, as needed, your protected health information to support our daily activities related to providing health care. These activities include billing, collection, quality assessment, licensing, and staff performance reviews. For example, we may disclose your protected health information to a billing agency in order to prepare claims for reimbursement for the services we provide to you. We may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment. For example, we will contact you at your home telephone number to remind you of your next appointment and/or mail a postcard appointment reminder to your home address. We will share your protected health information with other persons or entities who perform various activities (for example, a transcription service) for our Practice. These business associates of our Practice are also required by law to protect your health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that might interest you. For example, your name and address may be used to send you a newsletter about our Practice and our services.

Required by Law – We may use or disclose your protected health information if law or regulations requires the use or disclosure.

Public Health – We may disclose your protected health information to a public health authority who is permitted by law to collect or receive the information. For example, the disclosure may be necessary to prevent or control disease, injury or disability; report births and deaths; or report reactions to medications or problems with medical products.

Communicable Diseases – We may disclose your protected health information, if authorized by law, to a person who might have been exposed to a communicable disease or might otherwise be at risk of contracting or spreading the disease or condition.

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, or other regulatory programs.

Food and Drug Administration – We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events; track products, enable product recalls; make repairs or replacements; or conduct post-marketing review.

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 disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement – We may disclose protected health information for law enforcement purposes, including information requests for identification and location; and circumstances pertaining to victims of a crime.

Coroners, Funeral Directors, and Organ Donations – We may disclose protected health information to coroners or medical examiners for identification to determine the cause of death or for the performance of other duties authorized by law. We may also disclose protected health information to funeral directors, as authorized by law. Protected health information may be used and disclosed for cadaver organ, eye or tissue donations.

Research – We may disclose protected health information to researchers when authorized by law, for example, if their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Threat to Health or Safety – Under applicable Federal and State laws, we may disclose your protected health information to law enforcement or another health care professional if we believe in good faith that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security – When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel for activities believed necessary by appropriate military command authorities to ensure the proper execution of the military mission, including determination of fitness for duty; or to a foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information, under specified conditions, to authorized Federal officials for conducting national security and intelligence activities including protective services to the President or others.

Workers' Compensation – We may disclose your protected health information to comply with workers' compensation laws and similar government programs.

Inmates – We may use or disclose your protected health information, under certain circumstances, if you are an inmate of a correctional facility.

Parental Access – State laws concerning minors permit or require certain disclosure of protected health information to parents, guardians, and persons acting in a similar legal status. We will act consistently with the laws of this State (or, if you are treated by us in another state, the laws of that state) and will make disclosures following such laws.

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. Following are examples in which your agreement or objection is required.

Individuals Involved in Your Health Care – Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also give information to someone who helps pay for your care. Additionally, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person who is responsible for your care, of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and coordinate uses and disclosures to family or other individuals involved in your health care.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION – You may exercise the following rights by submitting a written request to our Privacy Officer. Our Privacy Officer can guide you in pursuing these options. Please be aware that our Practice may deny your request; however, in most cases you may seek a review of the denial.

Right to Inspect and Copy – You may inspect and/or obtain a copy of your protected health information that is contained in a "designated record set" for as long as we maintain the protected health information. A designated record set contains medical and billing records and any other records that our Practice uses for making decisions about you. This right does not include inspection and copying of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. You will be charged a fee for a copy of your record and we will advise you of the exact fee at the time you make your request. We may offer to provide a summary of your information and, if you agree to receive a summary, we will advise you of the fee at the time of your request.

Right to Request Restrictions – You may ask us not to use or disclose any part of your protected health information for treatment, payment or health care operations. Your request must be made in writing to our Privacy Officer. In your request, you must tell us: (1) what information you want restricted; (2) whether you want to restrict our use or disclosure, or both; (3) to whom you want the restriction to apply, for example, disclosures to your spouse; and (4) an expiration date. If we believe that the restriction is not in the best interests of either party, or that we cannot reasonably accommodate the request, we are not required to agree to your request. If the restriction is mutually agreed upon, we will not use or disclose your protected health information in violation of that restriction, unless it is needed to provide emergency treatment. You may ask us not to disclose certain information to your health plan. We must agree with that request only if the disclosure is not for the purpose of carrying out treatment and pertains solely to a health care item or service for which we have been paid out of pocket in full. You may revoke a previously agreed upon restriction, at any time, in writing.

Right to Request Alternative Confidential Communications – 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.

Right to Request Amendment – If you believe that the information we have about you is incorrect or incomplete, you may request an amendment to your protected health information as long as we maintain this information. While we will accept requests for amendment, we are not required to agree to the amendment.

Right to an Accounting of Disclosure – You may request that we provide you with an accounting of the disclosures we have made of your protected health information. This right applies to disclosures made for purposes other than treatment, payment or health care operations as described in this Notice and excludes disclosures made directly to you, to others pursuant to an authorization from you, to family members or friends involved in your care, or for notification purposes. The accounting will only include disclosures made no more than 6 years prior to the date of your request. The right to receive this information is subject to additional exceptions, restrictions, and limitations as described earlier in this Notice.

Rights Related to an Electronic Health Record – If we maintain an electronic health record containing your protected health information, you have the right to obtain a copy of that information in an electronic format and you may choose to have us transmit such copy directly to a person or entity you designate, provided that your choice is clear, conspicuous, and specific. You may request that we provide you with an accounting of the disclosures we have made of your protected health information (including disclosures related to treatment, payment and health care operations) contained in an electronic health record for no more than 3 years prior to the date of your request (and depending on when we acquired an electronic health record).

Right to Obtain a Copy of this Notice – You may obtain a paper copy of this Notice from us by requesting one.

Special Protections – This Notice is provided to you as a requirement of HIPAA. There are several other privacy laws that also apply to HIV-related information, mental health information, psychotherapy notes, and substance abuse information. These laws have not been superseded and have been taken into consideration in developing our policies and this Notice. Psychotherapy notes, specifically, are subject to stricter privacy standards and most uses and disclosures require authorization from you.

Complaints – If you believe these privacy rights have been violated, you may file a written complaint with our Privacy Officer or with the U.S. Department of Health and Human Services' Office for Civil Rights (OCR). We will provide the address of the OCR Regional Office upon your request. No retaliation will occur against you for filing a complaint.

CONTACT INFORMATION – Our Privacy Officer is Rena Lederer, PT, and can be contacted at this office or by calling our telephone number (732) 534-6707. You may contact our Privacy Officer for further information about our complaint process or for further explanation of this Notice of Privacy Practices.