HOPE Therapies, LLC
Speech-language therapy

Attendance and Cancellation Policy

In order to better service you and make quicker progress towards goals, regular attendance to therapy is imperative. The most common cause of lack of progress is inconsistent attendance. Please thoroughly read and initial next to your responsibilities outlined as follows:

_____ I am responsible for attending speech/language/voice therapy sessions as scheduled. I understand that I must maintain at least an **80% attendance rate**, or risk losing my appointment slot.

_____ In the event of a cancellation, I will provide as much notice as possible. "Non-emergency" cancellations require 24 hours notice and include vacations, preplanned medical appointments, family events, parties, sports events, lack of babysitter or anything that is not designated as "emergency". **If the session is not cancelled within 24 hours notice I understand I will be responsible to pay $25**. "Emergency" cancellations are accepted only for illness (fever within the last 24 hours, strep, unidentified rash, diarrhea, vomiting, or any highly contagious illness), illness of a family member, or death in the family. In the event of an emergency cancellation, I understand I still must notify the clinic on the day of the appointment to avoid a "no show" fee of $25.

_____ I understand that Hope Therapies, LLC may send me an email reminder the day before my scheduled appointment, as a courtesy. I recognize that **my attendance is not dependent upon the receipt of an email reminder.** The email below is my preferred email for receiving courtesy appointment reminders:

Email: _____

I have read, understand, and agree to the Hope Therapies, LLC Attendance and Cancellation Policy as outlined above.

Signature: _____ Date: _____

Printed Name: _____

If signing as a parent or guardian,

Name of patient: _____

Relationship to patient: _____

Financial Policy

Thank you for choosing Hope Therapies, LLC! We are intentional about finding ways to make therapy more affordable as we do not want cost to be a barrier to your child receiving services. If you have any questions regarding this policy, please contact our clinic at 615-241-0122 or info@hopetherapies.org.

Please note: **ALL PAYMENT IS DUE AT TIME OF SERVICE**

Payment is due at the time services are rendered. This includes applicable coinsurance and copayments and any deductible amount for participating insurance companies. For private pay patients, payment is due in full at time of service and there is a $5 prompt pay discount given. We accept payment by cash, personal check, or credit card (Visa, MasterCard, Discover). There is a service charge of $25.00 for any returned check.

Insurance:

We bill participating insurance companies as a courtesy to you. You are expected to pay any deductible and copayments at the time of service. Clients are responsible for confirming insurance coverage and any benefit exclusions. Please note that all insurance companies vary and speech-language therapy may or may not be a covered benefit by your insurance. If we have not received payment from your insurance company within 45 days of the date of service or if your insurance company denies payment for any billed services, you will be expected to pay any remaining balance in full.

Hope Therapies, LLC may discontinue care for any patient due to non-payment. Any patient's account that cannot be collected by our office according to the terms of this financial policy will be turned over to a collection agency and the client will be responsible for any associated fees incurred for the debt collection, including collection agency fees and attorney fees.

Acknowledgement:

I, _____, acknowledge and accept full and complete responsibility for payment of all services rendered by Hope Therapies, LLC and/or its consultants. I understand that I am responsible for prompt payment of any cancellation or no show fees incurred as outlined in the Attendance and Cancellation Policy. I give Hope Therapies, LLC permission to submit claims to my insurer. I also grant permission to Hope Therapies, LLC to submit any documentation requested by my insurer to process a claim. I have read, understand, and hereby agree to the Financial Policy of Hope Therapies, LLC.

Signature: _____ Date: _____

Printed Name: _____

If signing as a parent or guardian,

Name of patient: _____

Relationship to patient: _____

Release Forms

Hope Therapies, LLC will occasionally ask to use photos/audio/video of our patients for educational purposes or to allow the public to be informed of our services and activities. We would appreciate your permission for this use. Names will remain anonymous unless otherwise specified by you.

Photographs

I give permission to Hope Therapies, LLC to take and use photographic images for the following purposes (check all that apply):

- ☐ Training and/or educational purposes
- ☐ Use in marketing materials of Hope Therapies, LLC (e.g., website, blog, brochures, Hope Therapies LLC Facebook page)

Audio Recordings

I give permission to Hope Therapies, LLC to take and use audio recordings for the following purposes (check all that apply):

- ☐ Training and/or educational purposes
- ☐ Use in marketing materials of Hope Therapies, LLC (e.g., website, blog, Facebook page)

Video Recordings

I give permission to Hope Therapies, LLC to take and use video recordings for the following purposes (check all that apply):

- ☐ Training and/or educational purposes
- ☐ Use in marketing materials of Hope Therapies, LLC (e.g., website, blog, Facebook page)

I hereby waive any rights to royalties or compensation arising from or related to the use of the media. I understand that I may address any specific questions regarding this release by contacting Hope Therapies, LLC at 615-241-0122 or info@hopetherapies.org.

Signature: _____ Date: _____

Printed Name: _____

If signing as a parent or guardian,

Name of patient: _____

Relationship to patient: _____

Hope Therapies, LLC Notice of Privacy Practices

The U.S. Department of Health and Human Services (HHS) has established a "Privacy Rule" to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and help insure that personal health information (PHI) is protected for privacy. This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

We may use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. A written contract will be established with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request that we not use or disclose your health information as described above, but this request must be in writing.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will provide copies of your files for you upon request.

You have the right to see and receive a copy of your health information. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. We will update your information, but may not remove or alter information from earlier documents.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact us at Hope Therapies, LLC, 615-241-0122.

This notice goes into effect as of May 8, 2015.

Acknowledgement

I have received a copy of the Hope Therapies, LLC Notice of Privacy Practices.

Signature: _____ Date: _____

Printed Name: _____

If signing as a parent or guardian,

Name of patient: _____

Relationship to patient: _____