Assential Therapies Inc.
241 Golf Mill Center, Ste 200, Niles, IL 60714
Ph: (847) 699-9757, Fax: (847) 699-5037

PATIENT REGISTRATION

Date ___________

Patient Name (Please Print) ____________________________________
(Last) (First) MI

Parent Name/Person financially responsible for the minor: _____________________________

Date of Birth ____/____/____ Age____ Gender: __Male __Female
MM DD YY

Address____________________________________ City____________ ZipCode_________

Home Phone: (____)_________ E-mail (for appointments only)____________________________

Parent/Guardian-1________________ Relation to Patient_________ Day Phone ___________

Parent/Guardian-2________________Relation to Patient_________ Day Phone____________

(All fields must be completed by the INSURED)

Primary Insurance Co:_____________ Claims Address: ______________________________

Insurance Plan Name:__________________ Insured's Policy or Group # __________________

Insured's ID# ________________________ Insured's Name: ____________ ______________

Insured's Address: ____________________________________ Insured's DOB:____________

Employer's Name & Address: ____

Secondary Insurance Co:__________ Claims Address: ______________________________

Insurance Plan Name:__________________ Insured's Policy or Group # __________________

Insured's ID# ________________________ Insured's Name: ____________ ______________

Insured's Address: ____________________________________ Insured's DOB:____________

Employer's Name & Address: ____

Referring Information:

Person who referred you to us: ___________

Primary Care Physician (if different): _______________________

Address: ________________________________City: _______________ State____ Zip____

Physician's Phone #: _______________________ Fax #: _______________________

Do you have a written Physician Referral: ______ Yes _____ No

Reason for Referral:

The above stated information is complete and true.

_________________________________ ________________
(Signature of Patient, Parent or Guardian) Today's Date

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AUTHORIZATION FOR PAYMENT AND CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION

I authorize Assential Therapies Inc. to submit health insurance claims for services rendered and to release any information pertaining to filing and documentation for any insurance claims.

I authorize Assential Therapies Inc. to receive payment directly from my insurance company. If my insurance company sends payments to me for the services provided by Assential Therapies Inc. then I understand my obligation to return any monies received within five business days to Assential Therapies Inc.

I hereby state that I have fully disclosed all insurance coverage and the information is true. I understand that it is my responsibility to inform Assential therapies Inc. of any changes in employer or insurance. I am aware that if Assential Therapies Inc. does not have adequate health insurance information on file for me, the charges incurred will be my responsibility.

I, hereby give my consent to Assential Therapies Inc., to use or release all medical records, for the purpose of carrying out and coordinating therapy services, to physicians, health care professionals, insurance companies and attorneys involved in my/dependant's care, with the following exceptions:

____

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent form at any time by giving written notice of my desire to do so, to Assential Therapies Inc. I also understand that I will not be able to revoke this consent in cases where the therapists have already relied on it to use or disclose my health information or the health information of my child/children. Written revocation of consent must be sent to Assential Therapies Inc.

Signed: ______________________ Date: _________________

Patient's Name: _________________________________

Parent/Guardian's Name: ______________________________

Relationship (if patient is under 18 years of age):__________________

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ASSENTIAL THERAPIES INC FINANCIAL POLICY

Patient Name: **DOB**:

We, at Assential Therapies Inc., are committed to providing you with excellent therapy services. In turn, we expect your full co-operation such that the therapy continues to progress efficiently. Please review our financial policy stated below as it is beneficial to our professional relationship.

RATES FOR THERAPY

We charge a rate that is usual and customary in the area. The fees for services cover for therapy time, preparation time, and documentation time, consultation with therapists before or after therapy session.

APPOINTMENT CANCELLATIONS AND NO-SHOWS

At Assential Therapies, families always come first and we do our best to accommodate the schedule of the families. We understand that from time-to-time, we encounter emergency situations which are beyond our control. However, for efficient therapy, we must avoid disruptions by appointment cancellation and no-shows. If you are unable to attend a session due to illness or family emergency, please notify the office at least 24 hrs prior to the session. After each no-show or cancellation without notice, you will receive a warning letter reminding you of the No Show Policy. After the 2nd incident of no-show or cancellation without prior notice, you will be charged a $25.00 cancellation fee and your therapy time-slot will be made available to another patient.

PAYMENT POLICY

We are happy to submit claims to your insurance company on your behalf and/or provide relevant clinical information including reports and progress notes as needed. You are required to present a valid insurance card at every visit and as needed throughout your care. Please inform us immediately if there is a change of insurance. **Failure to report change of insurance information may incur full liability of payment for services to the patient**. It is ultimately the patient's responsibility to pay for all the fees for services. Insurance policies (even within the same insurance company) vary in terms of coverage for different therapy services. **It is the patient's/parent's/guardian's responsibility to confirm what your policy covers and comply with the policy requirements. Parents are fully responsible for therapy services that may not be covered by your insurance policy**. You should obtain the information regarding the coverage, i.e., if it is limited to certain number of visits or diagnosis codes or if pre-certification/authorization is necessary prior to beginning of services.

FOR EARLY INTERVENTION PATIENTS

We are required by law to bill your insurance company for the services provided with the exception of Developmental Therapy (DT). The DT services are billed directly to the State of IL. In the event that your insurance policy does not cover the recommended service, the parent/guardian agrees to assist Assential Therapies in obtaining denial letter or EOB from the insurance company that in effect states "Services not covered" or equivalent. This requirement by the State of Illinois is a MUST in order for Assential Therapies to bill EI for the services NOT covered by the insurance. **The parents must inform us regarding the change of insurance within five business days. Failure to do so will incur liability of payments for uncovered services by the state or new insurance company**.

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PRIVATE DT SERVICES PAST 3 YEARS OF AGE

Developmental therapy services are considered educational in nature and are not generally covered by insurance plans. The payment for private DT services is due in full at the time of the services.

FOR SELF PAY PATIENTS

The payment is due in full at the time of services.

METHOD OF PAYMENT:

All patient balances are due in full within 14 business days of the receipt of the invoice.

Our office accepts the following payment methods:
Exact cash, personal check, and credit cards (Visa / Master card / Discover).

For returned checks we assess a $35.00 NSF charge, and report to the local district attorney's office checks that are not paid within 2 weeks of being returned to our office.

If not paid according to terms, the patient understands that our office reports to an outside collection agency. In the event your account is turned over for collection, patient agrees to pay all additional fees accessed in the collection of the debt. These fees include collection agency fees and attorney fees.

I have read, understood and agreed to the above financial policy.

______________________________ ______________
PATIENT/PARENT/GUARDIAN NAME DATE

____
PATIENT/PARENT/GUARDIAN SIGNATURE

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL AND PERSONAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. Our Commitment to Your Privacy

Assential Therapies is committed to maintaining privacy of the protected healthcare information (PHI) of you or your dependants. Federal Law requires that:

- Medical information that identifies you or your dependent is kept private
- That you are given this notice of our legal duties and privacy practices in regard to the healthcare information about you or your dependants.
- Provide you information regarding how we may use and disclose your PHI, your rights, our obligations concerning the use and disclosure of your PHI.

B. What Types of Personal Information Do We Collect?

In order to provide you services we need information about you. We collect enrollment and other information. This information may come from you, your health care provider, your employer, or other health benefits plan sponsor, CFC office, and our affiliates. Examples include your name, address, phone number, social security number, date of birth, marital status, employment information, and/or health/medical history. This information may be in the form of health care claims and encounters, medical information, or a service request. We may receive your information in writing, by telephone or electronically.

C. How Do We Protect the Privacy of Your Personal Information?

Keeping your information safe is one of our most important duties. We limit access to your personal information to those who need it. We maintain appropriate safeguards to protect it.

D. How Do We Use and Share Your Information for Treatment, Payment and Health Care Operations?

To properly service your benefits, we may use and share your personal information for "treatment," "payment" and "health care operations." We may limit the amount of information we share about you as required by law. Our privacy policies will always reflect the most protective laws that apply. Below we provide examples of each.

Treatment: Medical information about you and/or dependant may be used to provide appropriate diagnostic and therapy services. The PHI may be used during IFSP meetings, and in communication with other health-care providers involved in the care of you, such as service

Co-ordinators, other treating therapists, nurses, physicians and other specialists. For example, we may contact your service coordinator to add or delete services.

Payment: We may use and share your personal information to determine your eligibility, coordinate care, review medical necessity, pay claims, obtain external review and respond to complaints. For example, we may use information from your health care provider to help process your claims. We may also use and share your personal information to obtain payment from others that may be responsible for such costs.

Health Care Operations: Assential Therapies office staff for may access Your PHI appropriate filing and copying of documentation contained in the record. Also, the PHI may be used and disclosed when necessary to prevent a serious threat to you / your dependant's health and safety or the health and safety of another person or the public. This disclosure would be limited to an entity that may be able to prevent the threat i.e. medical emergency personnel. The PHI may be disclosed for special purposes as permitted or required by law, including but not limited to community and public health activities and reports, administrative oversight, legal processes or court orders and law enforcement.

E. What Other Ways Do We Use or Share Your Information?

We may also use or share you personal information for the following:

Others involved in your health care: With your consent we may share certain personal information with a caregiver, such as your baby-sitter, nanny, grandparents, spouse, close personal friend, or others you have identified as being involved in your care or payment for that care. For example, to those individuals with knowledge of a specific claim, we may confirm certain information about it. Also, we may mail an explanation of benefits to the Central Billing Office (CBO).

Personal representatives: We may share personal information with those having a relationship that gives them the right to act on your behalf. Examples include DCFS representatives overseeing the care of a child in foster care or the foster parent.

Other situations: We also may share personal information in certain public interest situations. Examples include protecting victims of abuse or neglect; preventing a serious threat to health or safety. We may also share your information for Worker's Compensation; for national security and as required by law.

F. What About Other Sharing of Information and What Happens If You Are No Longer Enrolled?

We will obtain your written permission to use or share your health information for reasons not identified by this notice. If you withdraw your permission, we will no longer use or share your health information for those reasons. However, you understand that taking back any disclosures that have already been made with your authorization will not be possible.

We do not destroy your information when your care is terminated. We are required to retain the records of the care that we provided to you for up to seven years from the last date of service. Typically all the paper records are boxed up and stored at a secured location. After six years all the paper records are destroyed by shredding. The electronic record is password protected and is not accessible from outside the facility. The electronic record is destroyed by using appropriate procedures.

G. Rights Established by Law

Requesting restrictions: You can request a restriction on the use or sharing of your health information for treatment, payment or health care operations. However, we may not agree to a requested restriction.

Confidential communications: You can request that we communicate with you about your health and related issues in a certain way or at a certain location. For example, you may ask that we contact you by mail, rather than by telephone, or at work, rather than at home. We will accommodate reasonable requests.

Access and copies: You can inspect and obtain a copy of certain health information. We may charge a fee for the costs of copying, mailing, labor and supplies related with your request. We will notify you of any costs pertaining to these requests and you may withdraw your request before you incur any costs. To inspect and to obtain a copy of the medical information, you must submit your requests in writing to Assential Therapies Inc.

Amendment: You may ask us to amend your health information if you believe it is incorrect or incomplete. You must provide us with a reason that supports your request. We may deny your request if the information is accurate or as otherwise allowed by law. You may send a statement of disagreement. Your request for amendment must be made in writing and submitted to Assential Therapies Inc.

Accounting of disclosures: You may request a report of certain times we have shared your information. For example, sharing your information in response to court orders. All requests for an accounting of disclosures must state a time period that may not include a date earlier than 6 years prior to the date of the request and may not include dates before April 14, 2003. We will notify you of any costs pertaining to these requests and you may withdraw your request before you incur any costs.

H. Changes to This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medial information we already have about you or your dependant as well as any information we receive in the future.

I. To File a Complaint or Receive More Information

If you believe, your or your dependant's privacy rights have been violated, you may file a complaint with us or with the secretary of the department of Health and Human Services and you will not be penalized in any way for filing such a complaint. Smita S. Joshi, is the assigned privacy officer at Assential Therapies Inc who is responsible for the development, implementation and oversight of the policies and procedures pertaining to HIPPA.

I have received, read, and understood the notices of Privacy Practices from Assential Therapies Inc.

Patient Name_______________________________

Patient / Parent / Guardian Signature ________________________________

Date ___________________________