Cooper
Therapy Connections PLLC
(779) 234-8997

Speech Therapy
Occupational Therapy
Evaluations
Counseling
Feeding Therapy

# HIPAA Privacy Notice Acknowledgement

Cooper Therapy Connections is required by law to keep your health information and records safe.

This information may include:

- Notes from your doctor, teacher or other healthcare provider
- Medical history
- Test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared.

☐ I acknowledge that I have received a copy of Cooper Therapy Connection's HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.

☐ I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.

☐ I understand Cooper Therapy Connections cannot disclose my health information other than as specified in the notice.

☐ I understand that Cooper Therapy Connections reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client

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**Please Note: It is your right to refuse to sign this Acknowledgement.**
HIPAA Privacy Notice Acknowledgement

Office Use Only

I tried to obtain written Acknowledgement of our Privacy Notice from the patient/legal representative noted above. It could not be obtained for the following reason(s)

- An emergency prevented us from obtaining acknowledgment.
- The individual was unwilling to sign.
- A communication barrier prevented us from obtaining acknowledgment.
- Other: _____

_____ _____
Staff Member Signature Date

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# Attendance / Cancellation Policy

(Effective 10/1/2021)

Attendance and participation in therapy along with complete compliance with any associated home programs are essential for therapeutic success.

While Cooper Therapy Connections understands that illnesses and emergencies occur, we respectfully request that you avoid frequent cancellations or "no-shows". Please adhere to our following policy regarding providing our office with advance notification of any cancellations resulting from a conflicting appointment, vacation, obligations for work or family, or any other event.

All cancellations must be submitted 24 hours prior to your scheduled appointment.

☐ A fee of $50 may be assessed if the following occurs. This fee will be billed directly to the client, not their health insurance company, as medical insurance does not cover missed sessions.

- If cancellations are made in less than the required 24 hours.
- If the client fails to show up for a scheduled appointment.

☐ If you arrive late for a scheduled appointment, the session will still end at the scheduled time or may be canceled.

☐ If you fail to appear for an appointment (no show) without providing the appropriate advance notification for 5 or more appointments, the office will reserve the right to cancel all pending appointments and to no longer offer services to you as a client.

☐ I,_____, understand the attendance/cancellation policy and the risks of not adhering to it.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client

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# Payment Policy & Fee Schedule

Thank you for choosing our private practice to serve you. We are committed to providing you with the highest quality care. Please know that the timely payment of your bill is an integral part of our service and as such, this payment policy is an agreement between you and Cooper Therapy Connections for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you and your family member(s). As a client of Cooper Therapy Connections, you are required to carefully review and sign our payment policy.

**Fee Schedule**
**(Effective 1/1/24)**

| | |
|---|---|
| Speech and Language Therapy Session | $120/session |
| Speech and Language Evaluation | $300 |
| Occupational Therapy Session | $160/session |
| Occupational Therapy Evaluation | $200 |
| Individual Counseling Session | $160.00/session |
| Individual Tutoring | $60/session |
| Feeding Therapy | $120/session |
| Feeding Evaluation | $300 |

**Please read the following carefully**:
Currently, we accept the follow payment methods:

- Cash
- Check
- Credit Card
- Blue Cross PPO Insurance (not applicable for tutoring)

We will provide you with an invoice/receipt outlining services rendered and the amount charged for all visits.

**Insurance Information** (a copy of your insurance card is required)
Insurance Company: _____ Plan Type: _____
Policy Holder: _____ DOB: _____ 800# _____
Policy Number: _____Group Number: _____

Please select one of the following:

- I allow Cooper Therapy Connections to file claims for and in consideration of the provisions of **speech/language, occupational therapy, counseling services.** I hereby assign, transfer, and set over to Cooper Therapy Connections all of my rights and interests in insurance benefits for the services

rendered. I hereby authorize all payments to be made directly to Cooper Therapy Connections and will turn over any payments made to me for services to Cooper Therapy Connections.

- I intend to file claims for **speech/language, occupational therapy, and counseling services** directly to my health insurance.

- I do not intend to file any claims for **speech/language, occupational therapy, and counseling services** and opt to participate in the provider's private pay option. I agree that the patient is not a member of the Medicaid system. I understand that the payment is expected at the time of service.

**Please Read and check all boxes to acknowledge understanding and then sign below.**

- I understand that I am responsible for all costs / fees that any third-party payer (ex. insurance company, private school, etc) does not cover. In the event a third-party payer source determines that rendered therapy services are "not covered" or otherwise denied, I will be responsible for all outstanding charges. I understand that I will be billed accordingly and will be responsible for immediate payments. I also understand that Cooper Therapy Connections will not become involved in disputes between you and your third-party source regarding uncovered charges or reasons for denial.

- I certify that the information given above under the heading "Insurance Information" is correct to the best of my knowledge. I also understand that I am responsible for providing any changes to the status of my child's insurance coverage or will be financially responsible for the balance and may have a discontinuation of services. I understand verification of insurance benefits and/or submission of invoices and/or supporting documentation does not guarantee payment by the insurance provider, and the family (or other stated responsible party) is financially responsible for any charges incurred

- I understand that if fees are not paid in full, treatment sessions may be postponed or canceled until payment is received.

- I understand that all cancellations require 24 hours' notice and that there will be a $50 charge for any cancellations made less than 24 hours. This charge is my sole responsibility and will not be covered by a third-party source.

- I, _____, (client/guardian) understand the payment policy and the risks of not adhering to it.

_____ _____
Print Name of Client Date of Birth

_____ _____
Signature of Client, Guardian or Responsible Party Relationship to client

_____ _____
Private Practitioner/Witness Date

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# Authorization for Credit Card Use

By signing this form, you give Cooper Therapy Connections, PLLC permission to debit your account for the amount indicated on or after the service date. This is permission for current and future services as outlined in this agreement, and does not provide authorization for unrelated debits or credits to your account.

Name on Card: _____

Billing Address: _____

_____

Credit Card Type:

☐ Visa ☐ Discover
☐ Mastercard ☐ American Express
☐ HSA ☐ Other _____

Credit Card Number: _____

Expiration Date: _____ Card Identification Number: _____ (3 digits on back of card)

☐ I, _____ (client or parent/guardian name) authorize Cooper Therapy Connections, PLLC to charge fees rendered for therapy services to the credit card provided herein.

☐ I understand that the provided credit card will be charged for services rendered (after each session) and that I will receive a printed invoice as a receipt of payment.

Cardholder, please sign and date:

Print Name: _____ Signature: _____
Date: _____

Client Name: _____ Date of Birth: _____

Credit Card Authorization

**I authorize Cooper Therapy Connections, PLLC to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for therapy services, for the amount invoiced by the practice, and is valid for ongoing monthly and weekly services. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.**

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# Consent for Services

☐ I authorize Cooper Therapy Connections to render appropriate evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree, and understand that I have the right to refuse treatment or terminate services at any time by Cooper Therapy Connections in writing. In addition, Cooper Therapy Connections may terminate services by notifying me in writing.

☐ I do not give my consent or am withdrawing my consent regarding Cooper Therapy Connections rendering evaluation and therapy services to the client named below.

_____ _____
Print Name of Client Date of Birth

_____ _____
Signature of Client, Guardian or Responsible Party Relationship to Client

_____
Date

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# General Acknowledgement of Forms

☐ I hereby acknowledge and agree that I have read all of the forms and documents provided to me in connection with the evaluation and treatment provided by Cooper Therapy Connections.

☐ I understand the meaning and intent of the provided forms and agree to all content included.

☐ I have been given an opportunity to ask questions about the provided forms and all questions I've asked have been answered to my satisfaction by Cooper Therapy Connections.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client

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# HIPAA POLICY
# NOTICE OF PRIVACY PRACTICES

**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**.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.
HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

**Treatment** means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.

**Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

**Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of January 1, 2019, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact the following for more information:

The U.S. Department of Health & Human Services Office of Civil Rights