Express Yourself

SPEECH, LANGUAGE & DEVELOPMENTAL THERAPY

Thank you for choosing Express Yourself Speech, Language, and Developmental Therapy. Our mission is to provide a child and family centered therapy. We take a bottom up approach to the therapeutic process, which allows us to create a treatment plan that best supports each child and their family. At Express Yourself Therapy, we specialize in the treatment of children with a range of speech, language, and developmental disorders including regulatory disorders, autism spectrum disorders, and pervasive developmental disorders.

At Express Yourself Therapy we implement the Developmental Individual Differences Relationship based model (DIR®/Floortime). Extensive training and continuing education for all of our therapists is a priority. Custom designed spaces, equipment and programs support the most effective care for your child. We work to accelerate progress through empowering parents and enabling them to be the primary change agent for their child. We strive to provide collaboration with other disciplines including: occupational therapists, psychologists, behavior therapists, optometrists, teachers and school staff.

This packet includes information related to our policies. You will be asked to fill this packet out on an annual basis, as consistent with most medical health care providers.

Please read through this packet carefully and sign/initial where applicable. These policies and procedures reflect our most recent updates which will be effective January 1, 2015.

FINANCIAL POLICIES
(please initial and sign where applicable)

- _____ Sessions at Express Yourself Therapy are 50 minutes in length and will be billed at $150.00*. Group sessions vary in length and are billed at $100*/hour.

- _____Sessions outside of the clinic setting including team meetings and school visits will include a travel charge of $75 per hour.

- _____ Therapeutic phone calls, direct consultation, emails and text messages requiring over 15 minutes per month will be billed at $75 per hour.

- _____ Except in cases of sickness or emergency, 24 notice of cancellation is required. Sessions not cancelled 24 hours or more in advance will be billed.

- _____ Should your account be delinquent for 30 days you will be charged a 5% late fee monthly. You will be responsible for any costs of collecting any past due balances, including collection and litigation costs.

- _____ There will be a $25.00 late fee for any returned check(s)

- _____ Your account must be in good standing to receive any and all written records

I have read and understand the above stated financial policies.

Signature:_____ Date:_____

*** You may see varied rates billed to your insurance company due to contractual agreements with your specific provider. This will not increase your out of pocket expenses.**

CONSENT FOR VIDEOTAPING AND RELEASE OF INFORMATION

I hereby authorize the release of clinical information and videotaping, concerning myself/ child/ children as designated below for the purpose of:

*Please indicate your approval by initialing each category below:

_____Insurance Requests

_____Sharing pictures and videos of group sessions with other children in the group and their families

_____Professional/Paraprofessional Training

_____Interdisciplinary Team Meetings

_____Professional Presentation

Signature _____ Date_____

INSURANCE INFORMATION:

Insurance billing is provided to all families. Please provide your information below unless you are self pay:

Primary Insurance Company Name:

Address (City/State/Zip):

Phone Number:

Insurance Company:

Insurance ID Number:

Group Number:

Name of Insured:

Relationship to Child:

Child's Date of Birth:

Primary Insured's Date of Birth:

Please bring your insurance card with you on your first visit so that we can copy it for our records. Please notify us if any of your personal or insurance information changes.

BLUE CROSS BLUE SHIELD INSURANCE (ONLY):

The following providers are covered at an in-network level for BCBS:

Olivia Garber M.S. CCC-SLP; Laura Kyger M.S. CCC-SLP

We are Blue Cross Blue Shield In-Network Providers and will submit all BCBS claims and accept assignments of those benefits. Families with BCBS managed care plan must pay their co-pay at the time of services and rendered as stated in your benefit plan. For your convenience, we can apply co-payments to a major credit card with your authorization on file.

Please be advised that some (and perhaps all) of the services we render may be considered "non-covered" by BCBS. In this case, they are not considered necessary and thus are not covered under your medical insurance policy. You are personally responsible for those non-covered services.

I understand that my child's services will be billed directly to BCBS and that I will incur the following cost for services.

I have a family annual deductible of _____ before insurance begins paying for any services.

I have an individual annual deductible of _____ before insurance begins paying for any services.

I have a co-pay of _____ to be paid at every session ongoing.

I have a co-insurance of _____ that is also due to be paid at every session.

My child is allowed Speech Therapy sessions _____ times per calendar year.

I understand that my deductible payments, copay, and coinsurance will be charged to my credit card each appointment.

Signature:_____ Date:_____

The following are our policies that govern insurance claims (PLEASE KEEP FOR YOUR RECORDS):

To expedite your child's care, we will submit claims to BCBS, but cannot guarantee the coverage of your services.

You (the parent or responsible party), will pay all past due portions of your charges not covered by insurance, specified by the insurance. This portion is due in full at the time of receiving your monthly statement.

Our office does NOT guarantee that your insurance company will pay on claims. However, if for some reason, your insurance company pays differently than determined at the time of your visit, or your insurance claim is denied, you (the parent/ guardian) are then considered to be responsible for the full amount of the bill.

Insurance payments ordinarily are received within 30 to 60 days from time of submission. If your insurance company has not made payment to our office within 60 days, we request that you (the insured) pay the balance due, and then seek reimbursement from the insurance company when and if it is paid.

_____(Signature) I understand that the billing office will mail me a statement of services rendered once a month. I authorize them to charge my credit card accordingly per Express Yourself Therapy Policy.

NON-BCBS INSURANCE HOLDERS

I understand that my child's services will be billed directly to my insurance provider and that I will incur the following cost for services for out of network benefits.

I have a family annual deductible of _____ before insurance begins paying for any services.

I have an individual annual deductible of _____ before insurance begins paying for any services.

I have a co-pay of _____ to be paid at every session.

I have a co-insurance of _____ that is also due to be paid at every session.

My child is allowed Speech Therapy sessions _____ times per calendar year.

I understand that my deductible payments, copay, and coinsurance will be charged to my credit card monthly.

Signature:_____ Date:_____

The following are our policies that govern insurance claims (PLEASE KEEP FOR YOUR RECORDS):

To expedite your child's care, we will submit claims to your insurance company, but cannot guarantee the coverage of your services.

You (the parent or responsible party), will pay all past due portions of your charges not covered by insurance, specified by the insurance. This portion is due in full at the time of receiving your monthly statement.

Our office does NOT guarantee that your insurance company will pay on claims. However, if for some reason, your insurance company pays differently than determined at the time of your visit, or your insurance claim is denied, you (the parent/ guardian) are then considered to be responsible for the full amount of the bill.

Insurance payments ordinarily are received within 30 to 60 days from time of submission. If your insurance company has not made payment to our office within 60 days, we request that you (the insured) pay the balance due, and then seek reimbursement from the insurance company when and if it is paid.

_____ (Signature) I understand that the billing office will mail me a statement of services rendered once a month. My credit card will be charged monthly for the total amount due post insurance processing. For individuals who are self-pay, this will be the total amount for services provided.

CREDIT CARD AUTHORIZATION

_____(initial) I authorize Express Yourself Therapy to charge my credit card monthly

Card Type: _____

Cardholder's Name:_____

Cardholder's Zipcode:_____

Cardholder's Email:_____

Credit Card Number: _____

Expiration:_____

CVC:_____

I, _____, authorize Express Yourself Therapy to charge my credit card monthly for the total amount due post insurance processing. For individuals who are self-pay, this will be the total amount for services provided.

Signature of Cardholder:_____

Release of Information

I, _____, authorize Express Yourself Therapy, to provide those below with any information requested regarding the occupational therapy services for _____(Patient name)

This information includes but is not limited to the demographic data, written records, and billing records of client. Please include the Name, Title and Relation to child for each person/institution listed.

Name:_____ Title:_____

Name:_____ Title:_____

Name:_____ Title:_____

Name:_____ Title:_____

Name:_____ Title:_____

Name:_____ Title:_____

Signature: _____ Date:_____

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.

This Notice of Privacy Practices ("Notice") applies to Protected Health Information (defined below) associated with Group Health Plans (defined below) provided by Express Yourself Therapy to its employees, its employee's dependents and, as applicable, retired employees. This Notice describes how Express Yourself Therapy collectively we, us, or our company may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information and to provide individuals covered under our group health plan with notice of our legal duties and privacy practices concerning Protected Health Information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be mailed to all policyholders then covered by the Group Health Plan. Copies of our current Notice may be obtained by contacting Express Yourself Therapy at the telephone number or address below, or on our Web site at www.expressyourselftherapy.com

DEFINITIONS

Protected Health Information ("PHI") means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will

be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Your Authorization – Except as outlined below, we will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining coverage under the group health plan, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Uses and Disclosures for Payment – We may make requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims. We may also disclose your PHI for the payment purposes of a health care provider or a health plan.

Uses and Disclosures for Health Care Operations – We may use and disclose your PHI as necessary for our health care operations. Examples of health care operations include activities relating to the creation, renewal, or replacement of your Group Health Plan coverage, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to your Group Health Plan.

Family and Friends Involved in Your Care – If you are available and do not object, we may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals. For example, we may use our professional judgment to disclose PHI to your spouse concerning the processing of a claim.

Business Associates – At times we use outside persons or organizations to help us provide you with the benefits of your Group Health Plan. Examples of these outside persons and organizations might include vendors that help us process your claims. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations.

Other Products and Services – We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your PHI for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing Group Health Plan coverage, and about health-related products and services that may add value to your Group Health Plan.

Other Uses and Disclosures – We may make certain other uses and disclosures of your PHI without your authorization.

- We may use or disclose your PHI for any purpose required by law. For example, we may be required by law to use or disclose your PHI to respond to a court order.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for cadaveric organ, eye or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to workers' compensation agencies for your workers' compensation benefit determination.
- We will, if required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.

In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of Protected Health Information, as described above, we will restrict our uses or disclosure of your Protected Health Information in accordance with the more stringent standard.

RIGHTS THAT YOU HAVE

Access to Your PHI – You have the right of access to copy and/or inspect your PHI that we maintain in designated record sets. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI and must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). Access request forms are available from [Insert company name] at the address below. We may charge you a fee for copying and postage.

Amendments to Your PHI – You have the right to request that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested

amendments but will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your representative, and must state the reasons for the amendment/correction request. Amendment request forms are available from us at the address below.

Accounting for Disclosures of Your PHI – You have the right to receive an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, your accounting requests must be in writing and signed by you or your representative. Accounting request forms are available from us at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your PHI – You have the right to request restrictions on certain of our uses and disclosures of your PHI for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. We are not required to agree to your request but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. You may make a request for a restriction (or termination of an existing restriction) by contacting us at the telephone number or address below.

Request for Confidential Communications – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to us at the address below.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Complaints – If you believe your privacy rights have been violated, you can file a complaint with us in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact Melissa Grosvenor via telephone at (847) 345-3384 or via email melissa@expressyourselftherapy.com

EFFECTIVE DATE
This Notice is effective February 28, 2013.