# ADULT PATIENT REGISTRATION FORM

## Patient Information

Legal First Name_____M.I._____Last Name_____

Street City State ZIP

Address _____ _____ _____ _____

Home Phone_____Cell Phone_____Email_____

Birth Date_____/_____/_____ SSN_____

Gender: ☐M / F☐ Preferred Language:_____

Ethnicity:☐Hispanic/Latino ☐Non Hispanic/Latino | Race:☐Caucasian ☐African American ☐Asian Other_____

Referred by_____ Primary Physician_____

## Insurance Information

**Primary Insurance Company**_____

Address_____

ID #_____ Group #_____

Policy Holder Name_____ DOB_____

Employer_____ Relationship to Patient_____

**Secondary Insurance Company**_____

Address_____

ID #_____Group #_____

Policy Holder Name_____DOB_____

Employer_____ Relationship to Patient_____

Financial Policy: I authorize the release of any information necessary to process claims. I request payment of benefits to FOCUS Inc. I understand I am financial responsible for chares not covered by insurance. I hereby authorize to FOCUS Inc. and its employees and/ or agents to release all information, reports and records, if necessary for the purpose of treatment, payment, and healthcare operations, including a discussion of my medical condition to the Insurance provider, rehabilitation provider, employer, hospitals, and doctors.

If you plan has a co-payment, deductible and/ or co-insurance you will b e expect to pay your portion prior to receiving any service. You may be required to pay a minimum of 80% at the time of service until we verify your deductible has been met.

In the case of a divorce situation, the adult accompanying a minor patient is responsible for payment of service. Our office staff will not participate in any disputes which may arise with respect to financial liability due to legal custody agreements.

Payment is due at the time of service unless prior financial arrangements have been made with our business office. Any account balance is expected to be paid in full prior to new services being rendered. Should it become necessary for FOCUS Inc. to utilize the services of an outside collection agency, you may be held liable for collection agency fees and/ or attorney fees.

**Patient/Responsible Party Signature**_____**Date**_____

16635 Centerfield Drive, Suite 103 | Eagle River, Alaska 99577
Phone (907) 694-6002 | Fax (907) 694-6015 | www.focusoutreach.org

# FOCUS

**F**amily **O**utreach **C**enter for **U**nderstanding **S**pecial-Needs, Inc.

## MEDIA RELEASE

As part of our non profit outreach activities, FOCUS requests to use client images to promote services to the community through social media platforms, brochures, and our website.

In conjunction to this, your image (photo, video, etc) may be edited, copied, exhibited, published or distributed and the client waives their right to inspect or approve the finished product.

This material may be used in diverse public and promotional settings within an unrestricted geographic area.

Photographs may be used for the following purposes:

Public events and promotional purposes

Agency and program brochures and public documents

Public education purposes

Fundraising Events

Social Media, Websites

Digital and Television and print advertising

By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for promotional purposes.

**Full Name:** _____**Date:**_____

**Signature**:_____

☐ I wish to DECLINE permissions to release photos

**Signature:**_____**Date:**_____

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# FOCUS Outreach

## Authorization for Release of Information

Patient Name:_____ Date of Birth:_____

Patient authorizes communication with a primary care physician **other than the referring physician** (referring physician will be sent a copy of the evaluation and the plan of care to authorize continued service):

Physician:_____(M.D/D.O) Clinic:_____

Physician:_____(M.D/D.O) Clinic:_____

Patient authorizes communication with family/ friends regarding your **account and billing.**

Name:_____Ph:_____Relation:_____

Name:_____Ph:_____Relation:_____

I authorize FOCUS permission to release information to the person/organization listed above concerning:

- ☐ Evaluations
- ☐ Plan of Cares
- ☐ Discharge Summaries
- ☐ All information pertaining to my child's care

I hereby authorize FOCUS to use or disclose my Personal Health Information (PHI) as described below. I understand that, if the organization authorized to receive my PHI is not a health plan or a health care provider, the released PHI may no longer be protected by federal privacy regulation. Our Notice of Privacy Practices provides detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practice. It is available upon request.

**Signature of Patient:_____Date:_____**

**Printed Name:_____**

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# FOCUS

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**Please detach and turn in after initialing and signing.**

Patient Name_____

Patient DOB_____

Please detach and turn in after initialing and signing

Please read carefully and initial:

1. _____ I hereby understand the above Therapy Agreement Attendance and Financial Policy and agree to abide by it.
2. _____ 3 consecutive no-shows will result in you being removed from the therapy schedule. All applicable fees will be assessed.
3. _____ Clients may be subject to a $25 Cancellation Fee for late cancellations (appointments cancelled after 5 PM the day before your scheduled appointment).
4. _____ If you plan to discontinue services, two weeks written notice is required.
5. _____ Your insurance is a contract between you, your employer, and your insurance company. We are not a party to this contract and any unpaid fees are client responsibility.
6. _____ Our office requires notification of any changes in insurance with coverage within 30 days of the effective date.
7. _____ Co-pays will be collected at the time of services.
8. _____ Co-insurance will be collected via statement once an insurance carrier has paid on a claim.
9. _____ I understand that if there is an absence of greater than three weeks (including vacations and insurance issues) my child will be removed from the schedule and placed on the waiting list.

Patient Signature_____ Date_____

Printed Name_____

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# FOCUS

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ACKNOWLEDGEMENT

I acknowledge that I have received the three-page notice

Notice of Use of Private Health Care Information

Printed name of Client: _____

Signature:_____

Date: _____

Please return this page only to the FOCUS office. You can deliver this to the FOCUS administrative offices in Eagle River or use mail or fax:

FOCUS

16635 Centerfield Drive Suite 103

Eagle River, AK 99577

Fax: 907-694-6022

# FOCUS

**F**amily **O**utreach **C**enter for **U**nderstanding **S**pecial-Needs, Inc.

## THERAPY ATTENDANCE AGREEMENT

### ATTENDANCE

Your sessions are standing appointments. Consistent attendance is critical to achieve improvement. We require an attendance rate of 80%. We will track visits and notify you when attendance drops below this requirement. We are glad to work with you if scheduling problems arise, so please let us know if you are experiencing difficulties with your current therapy schedule. Please inform us of any vacations or out of town occurrences in advance so we can make necessary arrangements prior.

If you are planning to be out of town for more than 3 weeks at a time, we are unable to hold a therapy spot for you. Kindly let our front desk know of any long term absences.

### CANCELLATIONS

Consistent with our family centered mission, we strive to be reasonably flexible to schedule changes and conflicts. We request that you inform us of cancellations no later than 24 hours prior to a scheduled session. We understand that illness can have a sudden onset and therefore we allow one last minute cancellation per quarter. Any client cancellations of less than 24 hours will apply to the required attendance rate of 80%. Please be aware that 3 consecutive no-shows or attendance below 80% will result of removal of your child from the therapy schedule. If you need to discontinue services, please provide us with written notice two weeks in advance so that our therapists can finalize treatment plans and complete any necessary documentation.

I would like to receive Appointment Reminders:

☐ via Text

Cell Phone:_____

☐ via Email

Email:_____

☐ DECLINE Appointment Reminders

_____We ask appointments to be cancelled no later than 5pm the day before your scheduled appointment by calling the main desk at 907-694-6002.

_____Clients may be subject to a $25 Cancellation Fee for late cancellations (appointments cancelled after 5 PM the day before your scheduled appointment)

Signature of Patient:_____Date:_____

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## FINANCIAL POLICY

Insurance:

As a courtesy to our clients, we will bill your insurance carrier. Not all services are covered benefit in all contracts and some insurance carriers have an approved number of sessions or exclusionary clauses. Ultimately, it is the family's responsibly to obtain information from their insurance carrier regarding number of therapy appointments covered, issues with deductible, or co-insurance amounts. We will collect co-pays at the time of service and we accept cash, check, and credit cards. If you use Medicaid, there is no co-pay requirement. Please make your co-pay at the front desk at the time of your child's therapy visit. We will not bill co-insurance until the insurance company has paid for the service. Should you have any billing questions or require special consideration regarding your co-pays, please contact our chief finance officers, Keith Greene, 694-6002.

Because therapy appointments are weekly, charges can add up quickly. Some insurance companies take 3 or more months to pay on claims and this can leave families with a large balance. Accurate information on covered services is only available once a claim has been made. We have experienced some private insurance companies reporting that therapy services will be covered and then claims being denied. Within a private insurance company, there are many different policies based on the package purchases by your employer. Often the answer lies within the fine print or exclusionary clauses that are not written in your summary of benefits packet. Your insurance is a contract between you, your employer, and the insurance company. As such, we are not a party to that contract and only bill as a courtesy to our families. Below are standard rates for therapy services.

- Speech Therapy evaluation: $425.00
- 30-45 minute individual Speech Therapy session: $175.00
- 1 hour Speech Therapy group session: $75.00
- OT/ PT evaluation: $200-$300 (per 15 minute unit) — depending on complexity
- OT/ PT individual therapy session: $70.00 (per 15 minute unit)

**Change of Information:**

**It is your responsibility to notify us of any change in address or insurance coverage within 30 days. If we are no longer able to bill your insurance, your balance will be your responsibility.**

# FOCUS

FOCUS **F**amily **O**utreach **C**enter for **U**nderstanding **S**pecial-Needs, Inc.

## Notice of Privacy Practices Effective September 23, 2013

**This notice describes how your protected health information may be used and disclosed and how you can get access to this information.**

**Please review it carefully.**

This Notice describes the protected health information practices of FOCUS. We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. All FOCUS departments or programs are covered by this Notice and your protected health information may be shared among these divisions.

### Our Pledge Regarding Protected Health Information

We understand that information about health is personal. We will not disclose protected health information to others unless you give us permission to do so, or unless the law authorizes or requires us to do so. This Notice applies to all of the individual's records we maintain. It describes the ways in which we may use and disclose protected health information, and describes our obligations with regard to such information.

We are required by law to

- Keep protected health information private
- Provide notice of our legal duties and privacy practices with respect to protected health information;
- Notify affected individuals following a breach of unsecured protected health information;
- Give you this Notice of Privacy Practices; and
- Follow the terms of the Notice of Privacy Practices currently in effect.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of the Notice by calling the Privacy Officer/ Quality Assurance Director at (907) 694-6002, or stopping by the Privacy Officer's office at 16635 Centerfield Drive, Suite 103, Eagle River, AK 99577 and ask for the Privacy Officer/ Quality Assurance Director.

### How We May Use/Disclose Protect Health Information

The following are some of the different ways that we may use and disclose your protected health information:

For Treatment. We may use or disclose protected health information about your to facilitate treatment, rehabilitation or treatment through services provided by FOCUS. For example, we may disclose protected health information to other healthcare providers who are involved in taking care of you.

For Payment. We may use and disclose protected health information about you to get reimbursed for the services we provide to you, including such things as submitting bills to insurance companies (either directly or through a third party billing company), necessity determinations and reviews, and collection of outstanding accounts.

For Focus Operations: We may use and disclose protected health information for other FOCUS operations necessary to run FOCUS. For example, we may use protected health information in connection with: conducting quality assessment and improvement activities; licensing; personnel training programs; fraud and abuse detection programs; and general FOCUS administrative activities.

To Business Associates. There are some services provided by FOUCS through contracts with business associates. Examples include accounting, legal, training, and consulting services. Information shall be made available to business associates consistent with their need to know for purposes of providing services.

Health Oversight Activities. We may disclose protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure.

As Required by Law. We will disclose protected health information when required to do so by federal, state, or local law. For example, we may disclose protected health information when required by a court order.

To Avert a Serious Threat to Health or Safety. We may use and disclose protected health information when necessary to prevent a serious threat to your health and safety or the health and safety of another person. Any disclosure, however, would only be to someone able to prevent the threat.

Other Uses and Disclosures

We may also use and disclose your health information in the following circumstances, when permitted by law, and with only the minimum necessary information being disclosed:

- Appointment reminders
- Language interpreters
- Information about available treatments or products
- Funeral Directors/ Coroners/ State Medical Examiners
- Workers' Compensation
- Correctional Institutions (if in jail or prison)
- Law Enforcement
- Tissue and Organ donation
- Disaster relief
- Military and Veterans (if you are an armed forces member)
- Responses to legally compliant court orders
- National security

Other uses and disclosures of protected health information not covered by this Notice or the laws that apply to us will be made only with your written authorization. This includes the use or disclosure of psychotherapy notes, the use or disclosure of protected health information for marketing, or the sale of protected health information, which will require your express written authorization.

Your Rights Regarding Protected Health Information

You have the following rights regarding protected health information we maintain for you:

- Right to Inspect and Copy. You may come to our offices and inspect and copy most of the protected health information that we maintain. We will normally provide you with access to, or copies of, this information within 30 days of your request. We may also charge you a reasonable fee for you to copy any protected health information that you have the right to access. If your records are held in electronic format, you may also obtain an electronic copy if it is reasonably available. In limited circumstances, we may deny you access to your protected health information, and you may appeal certain types of denials.

- Right to Amend. If you feel that the protected health information that we have is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must provide a supporting reason, be made in writing, and be submitted to the Privacy Officer. If we agree to amend the information, we will generally amend the information within 60 days of your request and will notify you when we have amended the information.
  We may deny your request for an amendment if it does not meet the requirements listed above. In addition, we may deny your request if you ask us to amend information that: is not kept by or for FOCUS; was not created by us, unless the person or entity that created the information is not longer available to make the amendment; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

- Right to an Accounting of Disclosures. You have the right to request a list of disclosures, where such disclosure was made for any purpose other than treatment, payment or FOCUS operations. We are not required to give you an accounting of information that we have shared with our business associates or for which you have given us a written authorization.

  To request and accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six years or before April 14, 2003. Your request should indicate in what form you want the list (i.e. paper or electronic). The first list you request within a 12– month period will be free, and you may be charged for the cost of any additional lists. We will notify you of the cost and you may choose to withdraw or modify your request before any costs are incurred.

- Right to Request Restrictions. You have the right to request a restriction or limitation on the protected health information we use or disclose for treatment, payment or FOCUS operations. You also have the right to request a limit on the protected health information we disclose to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a transport or treatment that we provided. We are not required to agree to your request unless the disclosure is to a health plan for purposes of carrying out payment or FOCUS operations (not treatment purposes) and the information pertains solely to an item or service paid for fully out of pocket.

  To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must describe: (1) what information you want to limit; (2) whether you want to limit use, disclosure or both; and (3) to whome the limits shall apply, for example, your spouse.

- Right to Request Confidential Communications. You can request that we communicate confidentially with you about protected health matters. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to Privacy Officer. We will accommodate reasonable requests. Your request must specify how you wish to be contacted.

- Right to a Paper Copy of This Notice. You may request a paper copy at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy.

## Right to Revoke Authorization/ Permissions

If you provide us permission to use or disclose protected health information, you may revoke permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected health information about your for the reasons covered by your written authorizations. You understand that we are unable to take back nay disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

## Questions/ Exercising Rights

If you have any questions about this Notice or would like to exercise any of the rights contained herein, please contact: FOCUS Privacy Officer, 16635 Centerfield Drive Suite 103, Eagle River, AK 99577, or by phone (907) 694-6002.

## Complaints

If you believe your privacy rights have been violated, you may file a complain with FOCUS or with the Secretary of the Department of Health and Human Services. To file a complaint with FOCUS contact the Privacy Officer. All complaints must be submitted in writing. You will not be retaliated against or penalized for filing a complaint. The Secretary of DHHS can be reached at

Office for Civil Rights

U.S. Department of Health and Human Services

200 Independence Avenue. S. W.

Room 509F, HHH Building

Washington, D. C. 20201