



Helena Occupational Therapy Specialists, PLLC
1325 Euclid Ave #3 Helena, MT 59601
Phone (406) 422-7729 fax (406) 403-0588

GENERAL OFFICE RULES, POLICIES & REGULATIONS

Please Initial:

_____ 1. **Cancellations:** We understand that illness and family emergencies occur. If you need to cancel your appointment, please call 406-422-7729 at least 24 hours prior to your appointment. Most insurance companies require a certain level of therapy progression to continue coverage. As to not disrupt the therapy progression, you may be required to attend a make-up session within 7 days of your cancellation.

_____ 2. **No Show Policy/Termination:** After 3 non-verified cancellations or no shows, the provider reserves the right to terminate therapy services. The provider also reserves the right to terminate therapy services at any time for any reason.

_____ 3. **Late Arrivals:** Our goal is to provide the highest quality therapy during your time with us. We greatly appreciate your timely arrival to all scheduled appointments. If you are more than 15 minutes late, we will not be able to provide the quality care desired. You may be required to schedule a make-up session.

_____ 4. **Health & Safety:** For the safety of all our clients and staff, please give us a call 24 hours prior to your appointment to reschedule if you or anyone coming with you has a fever and/ or is contagious with any type illness, rash, disease, etc.

_____ 5. **Insurance/Responsible Party:** You are responsible for all costs associated with your (or for whom you are responsible) evaluation and/or treatment with Helena Occupational Therapy Specialists, PLLC. Please provide the most current insurance information and cards to our office. As a courtesy, we will send claims to your insurance company. Ultimately, it is your responsibility to pay your account in full regardless of payments made or not made by your insurance company. In the even you do not have insurance, or your insurance company does not cover occupational therapy, it is your responsibility to pay your account in full and personally collect any unpaid balances from your insurance company. Please notify us if your insurance changes prior to your next appointment so we can make the appropriate changes so you can receive your maximum insurance benefits.

_____ 6. **Payment Policy:** Payment is due at the time of service and/or upon receipt of invoice. Late fees incur after 30 days. Payments not received after 120 days are subject to collections. You will be responsible for any and all charges accrued as a result of collection and/or legal services used to collect your debt.

The insurance information I have provided Helena Occupational Therapy Specialists, PLLC is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Helena Occupational Therapy Specialists or insurance company to release any information required to process my claims.

I have read, agree with, and understand the provisions as outlined in the above office policies.



CLIENT/GUARDIAN SIGNATURE

DATE

CLIENT/GUARDIAN/RESPONSIBLE PARTY SIGNATURE

DATE

Helena Occupational Therapy Specialists, PLLC
1325 Euclid Ave #3 Helena, MT 59601
Phone (406) 422-7729 fax (406) 403-0588

BILLING AND PAYMENT POLICY

As a service to you, Helena Occupational Therapy Specialists will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amounts covered, and is not responsible for the collection of such payments in some cases insurance companies or third-party payers may consider such services as not reasonable or necessary or may determine that services are not covered. In such cases the person responsible for payment (the undersigned) of the account is responsible for payment of these services. Funds not paid by insurance companies or third-party payers must be paid within 60 days. Payments not received after 120 days are subject to collections.

The insurance information I have provided Helena Occupational Therapy Specialists is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Helena Occupational Therapy Specialists or insurance company to release any information required to process my claims.

Office Cancellation Policy

Payment is due at the time an invoice is received, unless prior arrangements have been made with the provider. At least twenty four hour notice is required for appointment cancellation. After three non-verified cancellations, the provider reserves the right to terminate therapy services; the provider also reserves the right to terminate therapy services at any time for ANY reason.

I have read, agree with and understand the provisions as outlined in the above office billing/payment and cancellation policy.

Client/Guardian Signature

Date



Client/Guardian Signature

Date

PERMISSION TO RECORD AND/OR PHOTOGRAPH

The use of recording and photography can be used as an adjunct to evaluation, assessment and treatment. The information captured is used solely for the purposes of documentation and/or assessment of progress. Helena Occupational Therapy Specialists will protect all videos and photographs and will follow all confidentiality rules for our patients. If recordings are taken, after reviewing the recording and using it as mentioned above, the data will be deleted. By signing below, you agree to allow yourself and/ or your dependent to be recorded and/or photographed.

Client/Guardian Signature

Date

Helena Occupational Therapy Specialists, PLLC
1325 Euclid Ave #3 Helena, MT 59601
Phone (406) 422-7729 fax (406) 403-0588

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Federal law says that we cannot share your health information without your permission except in certain situations. If you sign this form, you are giving us permission to share the health information you indicate below. This does not keep the information from being shared with more people once it leaves our office. This authorization is valid for no longer than one year. If you decide later that you do not want us to share your information anymore, you can sign the REVOCATION SECTION at the end of this form and return it to us.

Client's Printed Name: _____ Birth Date: _____

I give permission to Helena OT Specialists, PLLC to share and or receive the information checked below with:

NAME:

ADDRESS:

_____ CITY, STATE,

ZIP: _____



EMAIL: _____

PHONE: _____ FAX: _____

NAME: _____

ADDRESS: _____

CITY, STATE,

ZIP: _____

EMAIL: _____

PHONE: _____ FAX: _____

- Information about my care and treatment with the above person or group
- Information from a certain time period (Specific Dates): From _____ To _____
- All Information relating to a certain event or injury and dates: (must specify event and or dates)

Event _____

Date of Event _____

- Other (Specify) _____

Client's Signature: _____ Date: _____

Signature of Authorized Representative: _____ Date: _____

Relationship of Authorized Representative: _____ Date: _____

Witness Signature: _____ Date: _____



Phone (406) 422-7729 fax (406) 403-0588

PATIENT-PROVIDER E-MAIL COMMUNICATION CONSENT

I have read and understand the information outlined in the Patient-Provider Email communication policy provided to me by Helena Occupational Therapy Specialists.

NAME OF RESPONSIBLE PARTY

(Print)

E-MAIL ADDRESS(ES)

RELATIONSHIP TO CLIENT

CLIENT NAME

SIGNATURE OF RESPONSIBLE PARTY

DATE

HIPAA- PATIENT-PROVIDER PRIVACY CONSENT FORM

I have received the HIPAA Patient- Provider Consent Info Sheet. I have read and understand the ways in which my privacy will be protected. I have read and understand the procedures for emergencies, confidentiality, record keeping, insurance, billing, and I consent to treatment under the described conditions. I also authorize the release of information to my insurance company (if applicable) Please refer to HIPAA document included with these forms. For more information on HIPAA and the protection of your privacy please go to: www.hhs.gov/hipaa

**CLIENT
SIGNATURE** _____

DATE _____

RESPONSIBLE PARTY (SPECIFIC RELATIONSHIP) _____

DATE _____



WITNESS
SIGNATURE _____

DATE _____

PERMISSION TO TREAT

As the responsible party and/or Guardian, I give Helena Occupation Therapy Specialists permission to treat: _____

CLIENT

SIGNATURE _____

DATE _____

RESPONSIBLE PARTY (Specific

Relationship) _____

DATE _____

Helena Occupational Therapy Specialists, PLLC
21 N. Last Chance Gulch, Suite 200 Helena, MT
Phone (406) 422-7729 fax (406) 403-0588

HIPPA DISCLOSURES

Please take a moment to read about your rights under the Health Insurance Portability and Accountability Act and affirm the following authorizations for disclosure of protected health information.

Helena Occupational Therapy Specialists may use or disclose your PHI to carry out treatment, payment or other healthcare operations related to your care. Examples would be: medical consultations, referrals, and insurance claims on your behalf.

You have the right to:

Request access to yours/ your child's health record at any time

Request corrections be made to your/ your child's record

Request that all communications regarding your care be restricted from unsecure transmissions (Fax, Email, Voicemail) **TEXTING IS NOT HIPPA COMPLIANT.**



Complain about a perceived violation of your privacy to me, my licensing board, or US Office for Civil Rights

Refuse any of the following authorizations

I authorized Helena Occupational Therapy Specialists to release my health information including diagnosis and treatment if necessary, for other care providers, hospitals, labs or facilities to continue my/child's care.

I understand my rights as a patient/ parent of patient and have received a notice of privacy practices.

TEXTING: I acknowledge that texting to and from Sara Schweitzer and her employees/students/assistants is **NOT HIPPA compliant**. If I choose to text and receive texts, I am releasing Sara Schweitzer and her employees/assistants of any liability regarding texting as non- HIPPA compliant communication.

Signature:

Date: