FOCUS

FOLLOW OUR COURSE UNTIL SUCCESSFUL

4997 Royal Gulf Cir, Fort Myers FL 33966 Ph. 239-313-5049 Fax 239-313-5712

Consent for Treatment and Clinic Policies and Procedures

Please read and initial each portion of the following:

Private Insurance
We are considered in-network with MOST major insurance companies, however, if you carry an insurance we do not contract with, we will submit your bill directly to them, but you are responsible for follow-up with the insurance company regarding the processing of your claim.

Parent Initials _____

Medicaid Coverage
I have been informed of Medicaid coverage requirements.

_____
Signature Date

I hereby assign and set over to FOCUS, all claims damages, and causes of actions for the same arising out of any accident creating the need for me to have physical, occupational, or speech therapy services to the extent of any unpaid balance due to FOCUS, for physical, occupational, or speech therapy services. I understand this assignment does not relieve me of any obligation to pay FOCUS, myself.

Parent Initials _____

Photo Release:
FOCUS will occasionally take photos or videos of the patients during therapy sessions for purposes of marketing, advertising, etc. I understand that photos and video of my child may be used in brochures, newsletters, social networking sites, etc. and authorize such use.

Parent Initials _____

Internships:
FOCUS accepts therapy students as a part of promoting our profession. Therapy students may be involved in your child's care.

Parent Initials _____

FOCUS

FOLLOW OUR COURSE UNTIL SUCCESSFUL

4997 Royal Gulf Cir, Fort Myers FL 33966 Ph. 239-313-5049 Fax 239-313-5712

Animal Authorization

Dog therapy is in use at this clinic at times. I understand there may be a dog in the same room, building, or vicinity of therapy being provided. I hereby authorize FOCUS to incorporate animal therapy with occupational, speech, physical and/or ABA therapy, for the purpose of expanding my child's therapy opportunities. I have the following restrictions: _____.

Parent Initials _____

Supervision

All children require adult supervision at all times, either with a parent or a therapist. It is NOT appropriate to leave children alone in the waiting area and it is NOT SAFE to allow them to roam unsupervised in the treatment areas. Your children are responsible for cleaning up after themselves. Please be responsible.

FOCUS reserves the right to refuse services at the therapist/owner discretion.

Parent Initials _____

I have been offered a copy of/informed of FOCUS Notice of Privacy Practices. (HIPAA)

Parent Initials _____

I authorize the release of any information necessary to process this claim.

Parent Initials _____

I certify that the information I have given is true and correct to the best of my knowledge. I will notify you of any changes in my child's health status or the personal information I have given, including any changes in my child's insurance.

_____

Signature Date

FOCUS

FOLLOW OUR COURSE UNTIL SUCCESSFUL

4997 Royal Gulf Cir, Fort Myers FL 33966 Ph. 239-313-5049 Fax 239-313-5712

FOCUS FINANCIAL POLICY

PURPOSE:
FOCUS is committed to providing quality and affordable care to the patients it serves. We respectfully expect that payment is due by all individuals at the time services are rendered.

POLICY:
To ensure all patient balances are appropriately billed and collected.

PROCEDURE:
The following guidelines are to be followed during the billing and collection process:

INSURANCE:
FOCUS participates in most insurance plans. FOCUS will bill the patient's insurance company as a courtesy. Insurance claims will be filed weekly by our billing representative. The patient's insurance company may request patients to supply certain information directly; it is the responsibility of the patient to comply with their request. The patient is directly responsible for the balance of their claim whether or not their insurance company pays the claim. The patient's insurance benefit is a contract between the patient and the insurance carrier; FOCUS is not a party to that contract. If FOCUS does not participate in a patient's insurance plan, we will grant the patient an agreed upon discount on services for balances paid in full at the time of service.

REFERRALS:
It is the patient's responsibility to obtain referral or necessary insurance pre-authorization prior to the time of their visit or procedure. The patient will be seen when required documents are received in our office. We can assist with this process but will not be held responsible for such.

CO-PAY and DEDUCTIBLES:
All copayments and deductibles must be paid at the time of service. This arrangement is part of the patient's contract with their insurance company. FOCUS cannot interfere with that contractual relationship. FOCUS is unable to bill secondary insurances for co-pays, cost shares, and deductibles. This would be the responsibility of the patient.

NON COVERED SERVICES:
Some if not all services a patient receives at FOCUS may be non-covered or not considered reasonable or necessary by insurers. Patients must pay for these services at the time of their visit if applicable. For all BCBS patients, only one therapy services is able to be provided in one single day.

PROOF OF INSURANCE:
All individuals must complete our patient information form before seeing the therapist. In addition, a current copy of your valid insurance card and phone ID/Driver's License is necessary to confirm proof of insurance. If the patient fails to provide this information in a timely manner, they will be responsible for the balance of their claim.

FOCUS

FOLLOW OUR COURSE UNTIL SUCCESSFUL

4997 Royal Gulf Cir, Fort Myers FL 33966 Ph. 239-313-5049 Fax 239-313-5712

METHODS OF PAYMENT:
FOCUS accepts payments by cash, check, VISA, MasterCard, and Discover. All credit card and debit card transactions will incur a 4% fee to the cardholder.

PATIENT STATEMENTS:
Unless other arrangements are approved by FOCUS in writing, the balance of the patient's statement is due and payable when statement is issued, and is considered past due if not paid within 30 days of issuance.

NONPAYMENT:
If the patient's account is past due 30 days or greater and the balance has not been paid in full or payment arrangement made, the account may be sent to collections. In the event that the patient's account is balanced with a collection agency, a collection fee in the amount of 30% of the then outstanding balance will be added to the patient's account and shall become a part of the TOTAL amount due. Until balances are paid in full, therapists will treat patients on an emergency basis for previously treated injury or problem. Any allowed visits will require cash or credit card payment in full at the time of service, unless they have valid insurance. Patients may be terminated due to non-payment. If the patient has filed bankruptcy during the course of treatment, any future visits need to be paid by cash or credit card if the patient does not have valid insurance. If there is a valid insurance, any copayments or deductibles need to be paid at the time of service.

Patient Signature in acknowledgement of non-payment policy:

_____

Signature **Date**

Divorce:
In the case of divorce or separation, the party responsible for the account balance is the parent authorizing treatment for the child. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Personal Injury:
In the case of patients that are being treated as part of a personal injury lawsuit or claim, FOCUS requires verification from their attorney prior to their initial visit if applicable. Payment of the bill remains the patient's responsibility. FOCUS cannot bill the patient's attorney for charges incurred due to the personal injury case.

Treatment Record Copies:
If you require our office to provide a copy of your records, you must sign the appropriate Release of Information form. Copies will be 50 cents per page.

Miscellaneous Fees: There will be up to a $40.00 fee assessed for any additional paperwork that the therapist may need to fill out such as Special Equestrians Evaluation, grant letters, equipment recommendations etc. These services are not covered by insurance or Medicaid and require extra therapy time to complete. Please be advised that payment is due at the time of service.

Parent initials: _____

FOCUS

FOLLOW OUR COURSE UNTIL SUCCESSFUL

4997 Royal Gulf Cir, Fort Myers FL 33966 Ph. 239-313-5049 Fax 239-313-5712

Returned Checks:
A $35.00 service fee will be added to all checks returned for insufficient funds. If you check is returned, you will be required to pre-pay all future services at the time of service by cash, money order, or credit card.

Credit Balance Refunds:
FOCUS will make a good faith effort to capture all accounts that have been overpaid by a patient or insurance carrier and to refund the appropriate party within a reasonable time frame.
A refund will be issued when:

- A patient paid more than was based on their contractual agreement with their insurance carrier, and there is no other outstanding balance due by that patient to which the credit can be applied.
- A patient or insurance carrier erroneously issues a duplicate payment
- A payer erroneously remits payments to the wrong provider.
- The payer originally remits payment for a service that is later determined to be a non-covered service. In the situation, a refund may need to be issued to the payer, and a bill issued to the patient if said non-covered service is deemed by their insurance to be a patient responsibility.

Refunds will not be issued:

- If insurance is pending payment
- When there is a pre-existing balance due on the patient's account.

I have read and understand the financial policy of FOCUS and agree to the terms and conditions therein.

Signature **Date**

FOCUS

FOLLOW OUR COURSE UNTIL SUCCESSFUL

4997 Royal Gulf Cir, Fort Myers FL 33966 Ph. 239-313-5049 Fax 239-313-5712

SICK CHILD POLICY

All patients should be fever free and symptom free for 48 hours prior to therapy. Also, please do not bring other family members to our clinic that have been recently ill unless they also have been symptom free for 48 hours.

_____

Patient/ Guardian signature Date

CANCELLATION/NO SHOW POLICY

Due to the importance of following the plan of care recommendation for frequency of services and due to the high demand for therapy services, all patients are subject to the cancellation policy. **Cancellation notice must be given no less than 24 hours in advance. If the notice is not given within 24 hours, a $40 charge per discipline will be issued to the patient that must be paid before the next therapy session. In cases of unforeseen circumstances/sick child, cancellation notice must be given by 8:00 am for morning appointments and 12:00pm for afternoon appointments to avoid the $40 fee.** This fee WILL NOT BE COVERED BY INSURANCE and is the responsibility of the patient. Collection is required before the next therapy session or cancellation of services will take place. **Excessive absences due to illness may require a doctor's note to resume therapies and 5 missed visits within a 6 month period will result in discharge from services**. If you cancel for a period greater than two weeks, your appointment time will not be held open. Upon return from your leave, please contact us to reschedule. If you miss two appointments without calling at least 24 hours in advance, your appointment time may be released to another patient and you may be discharged from therapy.

I have read and agree to this policy and will adhere to the stipulations as outlined above.

_____

Patient/ Guardian signature Date

LATE POLICY

If you will be late to therapy, **NOTIFICATION IS REQUIRED**. If more than 15 minutes late without notification, a $40 fee may be assessed and your therapy session will be cancelled. This fee WILL NOT BE COVERED BY INSURANCE and is the responsibility of the patient. Collection is required before the next therapy session or cancellation of services will take place.

_____

Patient/ Guardian signature Date

FOCUS

FOLLOW OUR COURSE UNTIL SUCCESSFUL

4997 Royal Gulf Cir, Fort Myers FL 33966 Ph. 239-313-5049 Fax 239-313-5712

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ **Date of Birth:** _____

I request and authorize: _____ to release healthcare information of the patient to be used or disclosed to the following individuals and organization:

Name: FOCUS
Address: 4977 Royal Gulf Cir, Fort Myers FL 33966
Phone: 239-313-5049
Fax: 239-313-5712

The request and authorization applies to:

Healthcare information relating to the following: treatment, condition, and/or date, Evaluations, consultations, diagnostic testing results, medications and continuity of care.

This information for which I'm authorizing disclosure will be used for the following purposes:

- **Sharing with other health care providers as needed.**

- **Maximize communication with therapeutic interventions and physician recommendations and guidance.**

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless I specify differently, this authorization will expire twelve (12) months from the date signed below:

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Patient/Parent Signature: _____ Date: _____

FOCUS

FOLLOW OUR COURSE UNTIL SUCCESSFUL

4997 Royal Gulf Cir, Fort Myers FL 33966 Ph. 239-313-5049 Fax 239-313-5712

Member Consent Form
Insurance Processing for Payment

I _____ authorize J Kru Therapy, LLC to act on my behalf for processing claims as well as appealing denial of payments, reprocessing claims, and requesting a fair hearing trial when insurance payments are not provided in conjunction with my benefits plan.

Member Name: _____

Insurance: _____

Member #: _____

Authorized Signature of
Member/Parent of Member: _____

Date: _____

FOCUS
FOLLOW OUR COURSE UNTIL SUCCESSFUL

4997 Royal Gulf Cir, Fort Myers FL 33966 Ph. 239-313-5049 Fax 239-313-5712

Consent For Treatment

Therapist/ Therapist Training: Each patient receives 1:1 direct instruction from a licensed and/or certified therapist at FOCUS. We do our best to match your child to a therapist/therapists that will work well with your child's individual needs. We cannot guarantee that your child will always have the same therapist. All therapists at FOCUS provide quality care thus your child's interactions with professionals of different treatment styles will ultimately be the most beneficial to him/her. _____ initials

Communication from Therapists: Following all sessions, you will be provided feedback on your child's response to intervention. Most often the therapist will provide this feedback in person, however some information may not be suitable for your child (or others) to hear. If you prefer to communicate at a later time or in private, please let your therapist know in advance. All therapists can be emailed directly through their focusflorida.com email account. Furthermore, this feedback and recommendations for home carryover will be crucial to your child's success. _____ initials

Confidentiality: We believe you and your child deserve privacy as part of the quality therapy services they receive at FOCUS. This is one reason why we do not allow parents present in the session. If you or your child's therapist feel it is important for you to observe their session(s), a baby monitor may be available by request from the front desk. If you are welcomed to the back therapy gym for either a tour or meeting with the therapists, we ask that you do not ask questions regarding the care provided to children other than your own. Observations you make of other children must be kept confidential and should not be discussed with others under any circumstances. _____ initials

Safety: Some children that receive therapy at FOCUS have behaviors that negatively impact their ability to make progress. If your child is demonstrating behavior problems that could cause harm to themselves or others, we will be obligated to utilize crisis prevention intervention in order to keep themselves and others safe. In this event, we will provide you with a written incident report that will describe the event that occurred in detail. We will ask that you sign the incident report and you will be given a copy for your own records. If your child is in need of more intensive interventions to resolve these problem behaviors they will be referred for ABA therapy. ABA therapy can only be provided under a doctor's prescription. _____ initials

Treatment Plan: During the evaluation process, if your child was found to have skills that are not consistent with his/her same aged peers therapy will be recommended. Each therapy discipline including speech, occupational, physical, and ABA therapy will

4997 Royal Gulf Cir, Fort Myers FL 33966 Ph. 239-313-5049 Fax 239-313-5712

have a separate treatment plan that will guide the intervention provided to your child. Please direct questions regarding each treatment plan to that therapist. _____ initials

I have read and understand the aforementioned information regarding skilled therapy provided at FOCUS. I hereby authorize treatment according to the plan(s) of care that have been documented. I have been given a copy of my child's plan(s) of care and am able to ask questions at any time throughout the treatment plan.

_____ _____

Parent Consent Date