Across the Board THERAPY GROUP
SPEECH · BEHAVIORAL/ABA · OCCUPATIONAL · PHYSICAL

7552 Navarre Parkway, Unit 32
Navarre, Florida 32566
Phone: (850)939-3944
Fax: (850)939-3945

General Information:

Patient Name	Date of Birth	Age	M / F Gender

Person Providing Information	Relationship to Patient	Date

Address:		
Apartment:		
City:	State:	Zip code:
Mom Phone Number:		
Dad Phone Number:		
Email:		

Custody Status: _____Mother _____Father _____Both _____Joint Other: _____

Mother's Name: _____Age: _____Occupation: _____

Father's Name: _____Age: _____Occupation: _____

Emergency Contact	Relationship to Patient	Phone Number

How did you hear about Across the Board Therapy Group? _____

Primary Insurance:		
ID #:		
Group #:		
Name of Insured:	DOB of Insured:	
Phone Number:		

Secondary Insurance:		
ID #:		
Group #:		
Name of Insured:	DOB of Insured:	
Phone Number:		

Sibling's Name	**Sibling's Age**

Across the Board Therapy Group LLC Policies

Attendance.
At Across the Board Therapy Group, scheduled appointments are a bond between our therapists and our patients. This is our opportunity to provide the highest standard of care to each patient. To help us honor our commitment to your care, we ask all families to follow a few simple guidelines:

1. Arrive for your appointment on time
2. Provide at least a twenty-four (24) hour notice for cancellations
3. Limit number of cancellations
4. Honor our bond

We realize that emergencies happen and schedules change. However, appointments that ware habitually missed, cancelled, or changed will result in one of the following actions:

1. Loss of your regular appointment time
2. Reduction in number of weekly appointment
3. Discharge from this facility as a result of poor attendance

If we feel attendance patterns are habitually not meeting our expectations, we reserve the right to initiate the able procedures at our discretion. No show appointments will result in a $25.00 charge. That charge is not covered by insurance and will be the responsibility of the guarantor on the account. Failure to pay the charge will result in discharge from this facility. Cancelations at or during your scheduled therapy session are considered a no show.

Illness.
If your child is sick, please do not bring him/her to therapy until they are sufficiently well. Some of our patients may be medically fragile, therefore, do not bring sick siblings in the Clinic.

Payment.
All co-pays and private pay fees need to be **paid at the time of the service** unless an alternative payment schedule has been negotiated. Any unmet deductible or balance incurred for whatever reason will be invoiced after the claim is processed. Prompt payment is required within 30 days of invoice date.

Clinic.
Parents are to remain at the Clinic during their child's services. If it is necessary to leave, the parents must provide a phone number where they can be reached. Typically, pediatric sessions are every 30 minutes, therefore, parents are asked to be present five (5) minutes prior to the end of the session to discuss their child's progress and home activities.

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Date: _____

By signing this form, I represent that I am the legal representative of the patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the patient's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____

Date: _____

CONSENT TO TREATMENT

I hereby consent to ACROSS THE BOARD THERAPY, LLC, to provide therapy services to_____ as prescribed by the physician. I hereby authorize payment directly to ACROSS THE BOARD THERAPY, LLC, of the individual or group insurance benefits specified and otherwise payable to me. I understand I am fully responsible to ACROSS THE BOARD THERAPY, LLC, for all charges not paid by my insurance provider. ACROSS THE BOARD THERAPY, LLC, is authorized to release to said insurance companies, to Transworld Systems, Inc. any/all information listed above and/or medical records.

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Date: _____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the patient's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____

Date: _____

Name of Witness: _____

Signature of Witness: _____

CONSENT TO RELEASE INFORMATION

Patient's Name:	
Patient's Date of Birth:	
Patient's Address:	
Patient's Biological Parents' Names:	

I authorize Across the Board Therapy, LLC, to release and/or obtain information about the above patient from:

Primary Care Physician:	Address:	Telephone:	Facsimile:
Insurance Company:	Policy Number:	Address:	Telephone:
School District:	Address:	Telephone:	Facsimile:
Teacher:	Address:	Telephone:	Facsimile:
Other:	Address:	Telephone:	Facsimile:

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Date: _____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the patient's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____

Date: _____

Name of Witness: _____

Signature of Witness: _____

Notice of Privacy Practices
How Your Medical Information Is Used

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 applies to ACROSS THE BOARD THERAPY GROUP, LLC ("ACROSS THE BOARD"). ACROSS THE BOARD will use and distribute this Notice as its Notice of Privacy Practices and follow the information practices described in this Notice when using or disclosing records and information. It will share your health information as allowed and necessary, to carry out treatment, payment, or health care operations as described in this Notice.

Understanding Your Health Information

Each time you visit a hospital, clinic, physician, or other health care provider, a record of your visit is made. Typically, this health record contains your medical history, symptoms, examination and test results, diagnosis, treatment, care plan, insurance, billing, and employment information. This health information, often referred to as your health record, serves as a basis for planning your care and treatment and is a vital means of communication among the many health professionals who contribute to your health care. Your health information is also used by insurance companies and other third-party payers to verify the appropriateness of billed services.

Our Responsibilities

We are required by law to:

- Maintain the privacy of your health information during your lifetime and for years following your death.
- Provide you with an additional current copy of our Notice upon request.
- Abide by the terms of our current Notice.
- Notify you following a breach of unsecured protected health information in the event you are affected.

We will not use or disclose your health information without your written authorization, except as described in this Notice.

Uses And Disclosures Without Your Written Authorization

We may use and disclose your health information without your written authorization for Treatment, Payment and Health Care Operations

We will use and disclose your health information for treatment purposes

For example: Information obtained by a nurse, physician or other member of your health care team will be recorded in your record and used to determine the course of treatment. Health care team members will communicate with one another personally and through the health record to coordinate care provided. We will also provide your physician or subsequent health care provider with copies of various reports that should assist him or her in treating you in the future.

We will use and disclose your health information for payment purposes

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. We may disclose health information about you to other qualified parties for their payment purposes. For example, if you are brought in by ambulance, we may disclose your health information to the ambulance provider for its billing purposes.

We will use and disclose your health information for health care operations

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of health care we provide. In some cases, we will furnish your health information to other qualified parties for their health care operations. The ambulance company, for example, may want information

regarding your condition to help them know whether they have done an effective job of stabilizing your condition.

Health Information Exchange

We may make your protected health information available electronically through an information exchange service to other health care providers, health plans and health care clearinghouses that request your information. Participation in information exchange services also lets us see their information about you.

Teaching

Residents, fellows, and students in medicine, therapy, allied health and graduate studies, may be assisting with your care under the supervision of a licensed health care provider as a part of their professional health care training program.

Other Uses and Disclosures of your health information Without your Written Authorization

Notification

We may use or disclose health information to notify or assist in notifying a family member, personal representative, or another person responsible for your care of your location and general condition.

Communication with Family and Others

We may disclose relevant health information to a family member, friend, or other person involved in your care. We will only disclose this information if you agree, are given the opportunity to object and do not, or if in our professional judgment, it would be in your best interest to allow the person to receive the information or act on your behalf.

Directory

Unless you notify us that you object, or we are otherwise prohibited by law, we may use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy, and, except for religious affiliation, to other people who ask for you by name.

Business Associates

There are some services provided in our organization through contracts with business associates. When these services are contracted, we may disclose your health information to our business associates so that they can perform such services. However, we require the business associate to appropriately safeguard your information.

Appointment Reminders

We may contact you as a reminder that you have an appointment for treatment or medical care.

Treatment Alternatives

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

Fundraising

We may use and disclose your health information to our business associates and affiliated foundations for fundraising purposes. We may contact you in an effort to raise money for clinical programs, research and education. If you do not want us to contact you for fundraising efforts, you must notify ACROSS THE BOARD immediately.

Public Health

We may disclose health information about you for public health activities. These activities may include disclosures:

- To a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability;
- To appropriate authorities authorized to receive reports of abuse and neglect;
- To FDA-regulated entities for purposes of monitoring or reporting the quality, safety or effectiveness of FDA-regulated products; or
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- With parent or guardian permission, to send evidence of required immunizations to a school.

Workers' Compensation

We may disclose health information to the extent authorized and necessary to comply with laws relating to workers' compensation or other similar programs established by law. Correctional Institutions If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose to the correctional institution, its agents or the law enforcement official your health information necessary for your health or the health and safety of other individuals.

Law Enforcement

We may disclose your health information for law enforcement purposes:

- At the request of a law enforcement official and in response to a subpoena, court order, investigative demand or other lawful process;
- If we believe it is evidence of criminal conduct occurring on our premises;
- If you are a victim of crime and we obtain your agreement, or under certain circumstances, if we are unable to obtain your agreement;
- To identify or locate a suspect, fugitive, material witness or missing person;
- To alert authorities that a death may be the result of criminal conduct;
- To report a crime, the location of the crime or victim, or the identity, description or location of the person who committed the crime.

Health Oversight Activities

We may disclose health information for health oversight activities authorized by law. For example, oversight activities include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Threats to Health or Safety

Under certain circumstances, we may use or disclose your health information if we believe it is necessary to avert or lessen a serious threat to health and safety and is to a person reasonably able to prevent or lessen the threat or is necessary for law enforcement authorities to identify or apprehend an individual involved in a crime.

Specialized Government Functions

We may disclose your information for national security and intelligence activities authorized by law, for protective services of the president; or if you are a military member, to the military under limited circumstances.

As Required by Law

We will use or disclose your health information as required by federal, State or local law.

Lawsuits and Administrative Proceedings

We may release your health information in response to a court or administrative order. We may also provide your information in response to a subpoena or other discovery request, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Funeral Directors, Medical Examiners, and Coroners

We may disclose your health information to funeral directors, medical examiners, and coroners consistent with applicable law to carry out their duties.

Organ Procurement Organizations

Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Incidental Uses and Disclosures

There are certain incidental uses or disclosures of your health information that occur while we are providing services to you or conducting our business. For example, after surgery the nurse or doctor may need to use your name to identify family members that may be waiting for you in a waiting area. Other individuals waiting in the same area may hear your name called. We will make reasonable efforts to limit these incidental uses and disclosures.

<u>Uses and Disclosures That Require Your Written Authorization</u>

The following uses and disclosures will only be made with your written authorization:

- Uses and disclosures not listed above as permitted without your written authorization;
- most uses and disclosures of psychotherapy notes;
- uses and disclosures for our marketing purposes; and
- disclosures that constitute a sale of your health information.

Your authorization may be revoked in writing at any time except with respect to any actions we have taken in reliance on it.

<u>Your Health Information Rights</u>

You have the following rights regarding your health information:

Right to Inspect and Copy

You may request to look at your medical and billing records and obtain a copy. You must submit your medical records request to the Health Information Management Department. Contact the office listed on your billing statement to request a copy of your billing record. If you ask for a copy of your records, we may charge you a

copying fee plus postage. If we maintain an electronic health record about you, you have the right to request your copy in electronic format.

Right to Request Amendment

You may request that your health information be amended if you feel that the information is not correct. Your request must be in writing and provide rationale for the amendment. Please send your request to the Health Information Management Department. We may deny your request, and will notify you of our decision in writing.

Right to an Accounting of Disclosures

You may request an accounting of certain disclosures of your health information showing with whom your health information has been shared (does not apply to disclosures to you, with your authorization, for treatment, payment or health care operations, and in certain other cases). To request an accounting of disclosures, you must send a written request to Across the Board. Your request must state a time period that may not be longer than six years.

Right to Request Restrictions

You may request restrictions on how your health information is used for treatment, payment or health care operations or disclosed to certain family members or others who are involved in your care. We may deny your request with one exception. If we agree to a voluntary restriction, the restriction may be lifted if use of the information is necessary to provide emergency treatment. We are required to agree to your request that we not disclose certain health information to your health plan for payment or health care operations purposes, if you pay in full for all expenses related to that service prior to your request and the disclosure is not otherwise required by law. Such a restriction will only apply to records that relate solely to the service for which you have paid in full. If we later receive an authorization from you dated after the date of your requested restriction which authorizes us to disclose all of your records to your health plan, we will assume you have withdrawn your request for restriction. To request a restriction, you must send a written request to Across the Board, specifying what information you wish to restrict and to whom the restriction applies. You will receive a written response to your request.

Right to Request Private Communications

You may request that we communicate with you in a certain way in a certain location. You must make your request in writing to the patient registration staff and explain how or where you wish to be contacted.

Right to a Paper Copy of this Notice

You may request an additional paper copy of this Notice at any time.

Complaints

You may complain to us or to the Secretary of Health and Humana Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against your for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection to this form, please ask us to explain. Signature below confirms acknowledgment of our Privacy Practices

We reserve the right to change this Notice as our privacy practices change and to make the new provisions effective for all health information we maintain.

Name of Parent/Guardian: _____
Signature of Parent/Guardian: _____
Date: _____
If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the patient's behalf with respect to this authorization form.

Name of Legal Representative: _____
Signature of Legal Representative: _____
Date: _____
Name of Witness: _____
Signature of Witness: _____

HIPAA RELEASE OF INFORMATION
AUTHORIZATION FORM

I, _____hereby authorize ACROSS THE BOARD THERAPY GROUP, LLC, and its affiliates, its employees and agents (collectively "ACROSS THE BOARD"), to release to _____ my personal health information maintained by ACROSS THE BOARD (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid from the date of my/my representative's signature below and shall expire on the date my coverage ends with ACROSS THE BOARD.

I understand that I have a right to revoke this authorization by providing written notice to ACROSS THE BOARD. However, this authorization may not be revoked if ACROSS THE BOARD, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Date: _____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the patient's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____

Date: _____
Name of Witness: _____
Signature of Witness: _____

Across the Board Therapy Group
7552 Navarre Parkway, Suite 32
Navarre, FL 32566
Phone: 850-939-3944
Fax: 850-939-3945

Permission to Use Photograph

I grant to ***Across the Board Therapy Group***, its representatives and employees the right to take photographs of me, my child and my property. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. I authorize ***Across the Board Therapy Group***, its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that ***Across the Board Therapy Group***, may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and web content.

I have read and understand the above:

Signature: _____

Printed Name: _____

Address:_____

Date: _____

Release for Appointment Reminders

I, _____(Print), hereby authorize Across the Board Therapy Group to send me appointment reminders via e-mail or text message using the following information.

Email reminders may contain patient or clinic information such as, but not limited to, patient first name and clinic location.

Patient / Guardian Contact Information:
(Please print clearly and legibly)

E-mail: _____

Cell phone: _____

Patient / Guardian (Print):_____

Signature: _____

Date:_____

Note to Office Managers: *Confirm that the E-mail and Cell Phone provided above match the information in the patient information screen.*

AUTHORIZATION
TO PICK UP A CHILD FROM
ACROSS THE BOARD THERAPY GROUP

Name of Child(ren): _____

I hereby inform Across the Board Therapy Group that the people listed below are authorized to pick up the above named child(ren) at anytime. Accordingly, Across the Board Therapy Group is hereby instructed to release my child(ren) into the care of the following people whenever they come to Across the Board Therapy Group.

AUTHORIZED PICK-UP PERSON:

Name:	Relationship to Child:	Phone Number:
1.		
2		
3.		
4.		

I understand that:
1. Parents/guardians must inform Across the Board Therapy Group (call, leave a note at drop off) of the name of the person who is picking up their child on any day when they themselves are not.
2. The “Authorized Pick-Up Person” **must be at least 18 years old** and may be asked to provide a photo ID to the staff.
3. This authorization shall remain in force until edited or rescinded in writing by the signers of this authorization.
4. Children will not be released to persons who fail to provide acceptable identification upon request.

Authorized by:

_____

Parent/Guardian Signature Date

_____

Parent/Guardian Signature Date