Paloma Behavioral

Speech and Language Therapy Services

410 N. Wickham Rd.
Melbourne Florida, 32935
Phone: (321) 622-6884

Paloma Behavioral
Speech and Language Therapy
CONSENT/AUTHORIZATION FORM

Date: _____

CONSENT FOR TREATMENT

I authorize Paloma Academy to perform Speech and Language Therapy. I have been informed of the reason for therapy, along with the expected benefits.
The therapy was explained to me in detail and all my questions were fully answered. Understanding this, I authorize Paloma Academy to consent to treat
_____.
(Name of patient if minor)

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

RELEASE OF MEDICAL RECORD

In order to ensure proper follow-up and continuity of care, I agree that a copy of the medical record may be released to my physician, and designated referring physician and/or the provider who referred me. I authorize Paloma Academy to release the medical records of _____ as explained above.

INSURANCE AUTHORIZATION

I request that payment of authorized benefits be made to Paloma Academy on my behalf, for any services provided to me. I authorize any holder of medical and other information about me to release to Medicaid and its agents, any insurance company, any other third-party payer, state medical assistance agency or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits of benefits for related services. I agree to pay all charges not covered by a third - party payer. I authorize a copy of this authorization to be used in place of the original. I understand that filing insurance is a courtesy and not an obligation. I also understand that the contract is between myself and the insurance carrier, not the practice and the insurance carrier.

_____ _____
Parent or person authorized to consent for patient Date

_____ _____
Name of patient Date of birth

Patient Financial Agreement

Thank you for choosing Paloma Academy for Speech and Language Therapy. The following is a statement of our Financial Policy, which we require you to read and sign:

Please be aware that insurance may not cover 100% of your therapy care and a copay may be required. Copay's will be billed monthly. There will be a 5% late fee added if payment is not received within 7 days of the first of the month. For your convenience, we accept cash, check, and online payment.
The therapy rate for private pay (non- insurance) is $90.00 an hour.
Please indicate that you have read and understand our policies regarding treatment insurance coverage.

- I have read and understand this Financial Agreement
- I authorize and consent to the release of medical information necessary to bill and process insurance claims
- I authorize the payment of benefits directly to Paloma Academy
- I agree to pay all charges not covered or paid by my insurance company

_____ _____

Signature of responsible Party Date

Paloma Academy Speech and Language Therapy Services

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM EFFECTIVE DATE OF THIS NOTICE: April 01, 2023

I, _____ , have received Paloma Academy's Notice of Privacy Practices.

_____

Patient's Name

_____ _____

Signature of Parent/Patient Date

_____

Printed Name of Parent/Patient

NOTICE OF PRIVACY PRACTICES:

New federal laws require us to give you this Notice about our privacy practices regarding your protected health information. This is effective as of April 01, 2023, and will remain in effect until we replace it.

PLEASE REVIEW NOTICE CAREFULLY.

HOW DO WE PROTECT YOUR INFORMATION?

Our practice is dedicated to maintaining the privacy of your Protected Health Information (PHI). We maintain physical and procedural safeguards to protect your personal information. We establish confidentiality agreements with contracted parties that receive non-public personal, financial and health information about you. Our office will make reasonable efforts to disclose only the minimum necessary protected information to accomplish the intended purpose. The terms of this notice apply to all records containing your PHI that are created or retained by this practice. We reserve the

right to change our privacy practices and terms of this notice at any time, provided such changes are permitted by law. Before we make a significant change to our privacy procedures, we will change this Notice and make the new Notice available upon request.

HOW DO WE USE YOUR PROTECTED HEALTH INFORMATION (PHI)?

1. **Treatment.** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. Many of the people who work for our practice, including but not limited to, our therapists may use or disclose your PHI in order to treat you or to assist others in your treatment. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. **Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. We may disclose our PHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Health Care Operations.** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. **Persons Involved In Care**. If you are available and do not object, we may disclose your PHI to your family, friends, and others involved in your care or payment of a claim. If you are unable 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 judgement to share PHI with your spouse concerning the processing of a claim. Your authorization may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time.

Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose our protected health information:

1. **Disclosure Required by Law.** We may disclose your health information when we are required to do so by law. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release PHI if asked to do so by a law enforcement official. We will require adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law).

2. **Serious Threats to Health or Safety.** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

3. **National Security and Military.** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to a correctional institution or law enforcement official having lawful custody of protected health information of a patient under certain circumstances.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Paloma Academy specifying the requested method on contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of you PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of you PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we

are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing. Your request must be described in a clear and concise fashion:

(a) the information you wish restricted.

(b) whether you are requesting to limit our practice's use, disclosure or both; and

(c) to whom you want the limits to apply.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to Paloma Academy in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment.** You may ask us to amend your health information. To request an amendment, your request must be made in writing and explain why the information should be amended. We may deny your request under certain circumstances.

5. **Accounting of Disclosures.** You have the right to request an accounting of certain disclosures made by us of your PHI. Use of your PHI as part of the routine patient care in our practice is not required to be documented.

For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing and may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. **Right to Provide Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you

revoke your authorization, we will no longer use or disclose your PHI for the reason described in the authorization. Please note, we are required to retain records of your care.

8. **Right to a Copy of This Notice.** You have the right to a paper copy of this Notice upon request by contacting

Paloma Behavioral Speech and Language Therapy Services

I have received read and understand the privacy practices.

_____

Signature of responsible person (if patient is a minor)