ADVANCED
THERAPY SOLUTIONS

Patient Handbook

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Welcome to Advanced Therapy Solutions, LLC!

We are dedicated to providing quality therapy services to you. Our services cover a continuum of care from pediatrics to geriatrics in order to meet the varied needs of our patients in our community. Our mission is to provide compassionate, personalized, and specialized evidence-based therapy services that allow both adults and children to overcome obstacles in order to accomplish personal goals.

The entire staff at *Advanced Therapy Solutions, LLC* is committed to upholding the following values:

• We value treating our patients and each other with the same courtesy, respect and professionalism we want for ourselves.

• We value the thoughts and opinions of our patients and staff. We will respectfully listen to the input of others on how to continually improve our goals, policies, and procedures. We encourage interaction, discussions, and the exchange of ideas to improve our services.

• We value providing the most effective and efficient treatment plan for our patients by combining the therapeutic process with education to enhance development.

• We value providing the highest quality service at the lowest possible cost, with the best utilization of our resources.

• We value integrity and strive to maintain honesty and good ethics in all relationships.

• We value and respect the uniqueness and dignity of all individuals.

• We value having a positive, cooperative relationship with our community medical staff and schools to provide a safe and consistent continuum of care. We believe that it is important to include the patient, family, physicians, and teachers in developing a treatment plan to ensure optimal outcome. The individual needs of each patient will determine the plan and duration of treatment.

• We value creating a caring environment in which to respond to our patients with the utmost compassion.

The key to a successful experience in our office is understanding all aspects of the therapy services being provided. This Patient Handbook contains very important information about our services, financial obligations, insurance guidelines, policies, and regulations. Please read all information carefully, share it with family members, and let us know if you have any questions or concerns we can address!

Section 1: General

1. ***Scheduling-*** Therapy sessions at *Advanced Therapy Solutions, LLC* will be scheduled based on the therapist's professional discretion. The individual needs of each patient will determine the plan and duration of treatment. Sessions are typically 30, 45, or 60 minutes in length with the exception of initial evaluations, re-evaluations, or special sessions which may take longer. Length and frequency (e.g. number of sessions per week) of therapy sessions will be determined as deemed appropriate by the therapist based on the patient/client's individual condition, level of severity, needs, and treatment plan. Sessions are to be held at *Advanced Therapy Solutions, LLC's* clinic office unless otherwise deemed appropriate and acceptable to be held at an outside location (e.g. patient's home, daycare, or referring physician's office) at the therapist's discretion. All terms and conditions apply regardless of service location.

2. ***Plan of Care-*** *Advanced Therapy Solutions, LLC*'s therapists will make every effort to provide patients with an accurate estimate of time required to reach goals as stated in the patient's individualized plan of care based on initial evaluations and re-evaluations as deemed appropriate. However, due to various circumstances, modifications may need to be made to the plan of care, the frequency, and/or duration of the sessions throughout the course of treatment at the therapist's professional discretion. Therapy outcomes are not guaranteed and prognosis is determined on a case-by-case basis.

3. ***Discharge from Treatment-*** Both the patient/responsible party and the treating therapists have the right, at any point, to terminate services. If progress is not being made as determined by skilled therapeutic assessment, re-evaluation, or absence of data showing progress the *Advanced Therapy Solutions, LLC* therapists reserve the right to terminate services at any time based on their professional knowledge and opinions. While the therapists at *Advanced Therapy Solutions, LLC* will make every effort to achieve the goals stated in the plan of care; it is not guaranteed that all objectives will be met as anticipated. Termination of services may also occur after the patient has completed his/her treatment plan, if a physician no longer deems therapy services necessary, or if insurance does not cover ongoing services and a family is unable to pay out-of-pocket for services. Patients may also be discharged due to irregular attendance or inconsistent compliance with treatment recommendations at the therapist's professional discretion.

4. ***Providers-*** In some cases, for scheduling purposes or in order to facilitate patient gains, more than one rendering therapy provider throughout the course of treatment may see patients. Advance notice will be given to the patient or parents/guardians.

5. ***Student Observers and Interns-*** *Advanced Therapy Solutions, LLC* may contract with local university programs to accept student observers and interns. Our goal is to provide the best treatment outcomes for all patients and provide the best learning experience possible for any students present. *Advanced Therapy Solutions, LLC* will ensure that all students have been educated in HIPAA guidelines, have signed confidentiality statements, and will abide by all policies and regulations. Licensed therapists will always properly supervise students according to national and university

regulations. If you would prefer not to have a student observer or intern present during your session, inform the treating therapist prior to your session, and this will be accommodated at your request.

Section 2: Financial

1. ***For your convenience-*** *Advanced Therapy Solutions, LLC* accepts cash, checks, Visa, Mastercard, Discover, and American Express as forms of payment. Therapy is an authorized expense for HSA/FSA cards, which are also accepted at *Advanced Therapy Solutions, LLC*. We are an in-network provider for Medicare and Medicaid and most private insurances, we will file the claims for you. Please inquire to ensure in-network status; other insurances are those plans that we do not participate in. You may be responsible for payment in full at the time of service. As a courtesy, if at any time we are able to file your out-of-network claim, we will file on your behalf.

2. ***Rates***- Evaluation and treatment of each area of concern will be billed separately, according to *Advanced Therapy Solutions, LLC's* current fee schedule rates. Current fee schedule rates are available upon request. Evaluations and treatment session rates are subject to change at any time. If any fee schedule changes occur during a patient's course of treatment, the patient will be notified.

3. ***Insurance-*** Insurance is not a guarantee of coverage. Some insurance companies do not cover all services. Please read and learn your benefit plan. Please keep in mind that you are personally and financially responsible for the cost of all therapy services provided to you by Advanced Therapy Solutions, LLC. As such, it is within your rights to file appeals to request that services be covered (even if they are not typically covered by that plan), etc. You are paying for the insurance so that they can pay for your medical services. Please do not hesitate to become involved on behalf of your behalf to promote the best care for your family. Please notify us of any changes in insurance coverage. We strive to keep open communication in regards to insurance and payment.

4. ***Payment-*** For insured patients, co-payments, deductibles, and coinsurance amounts are due at the time of service. The remaining balance will then be billed to the patient's insurance company. After the insurance claim has been settled, if it is determined that there is an overpayment on the patient's account, a credit will be applied to the patient's account or a refund will be issued. Patients will be billed monthly for services. The statement should reflect charges to your insurance company, payments received from you and your insurance company and the remainder owed.

5. ***Self-pay Patients***- Self-pay patients are those patients who do not have insurance coverage. *Advanced Therapy Solutions, LLC* also offers reduced self-payment options for qualifying individuals; please contact us for more information on this policy. Payment is due at the time of service. If payment is not received at the time of service, the account will become delinquent and no further sessions will be held until the outstanding balance is paid in full.

6. **Outstanding Balances-** If a family does not pay a bill within 30 days of receipt, there will be a 10% late fee added to the account for each 30 days outstanding, fees will be accrued on the entire balance (including late fees from prior months). If the patient does not make effort to pay or fails to respond within 60 days, this constitutes refusal to pay. At this point in time, *Advanced Therapy Solutions, LLC* can explore options not limited to but including offering the patient a payment plan or utilization of collection services. If an outside collections agency is utilized the patient will be responsible for all collections or attorney fees accrued.

7. ***Returned Checks-*** *Advanced Therapy Solutions, LLC*'s accepts checks as a form of payment; however, a fee of $25 will be added to the unpaid balance for returned checks and no further sessions will be held until the patient's balance is paid in full.

Section 3: Arrival

1. ***Attendance-*** In order to ensure success, regular attendance is needed as well as completing any home program outlined by the treating therapist. Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee to the card on file. Appointments may be rescheduled within the same week to avoid being charged a cancellation fee.

   Advanced Therapy Solutions, LLC expects that you will uphold an attendance of at least 85%. If your attendance falls below 85% you will be notified. If it continues to fall, and falls below 75% or if you miss 3 consecutive therapy sessions we reserve the option to discharge you from services or your appointment slot may be reassigned. We strongly encourage you to arrive on-time for all therapy sessions in order to ensure the best use of your appointment time. Your success is important to us and is greatly dependent upon your commitment to consistent attendance and on-time arrivals. We strongly encourage you to arrive on-time for all therapy sessions in order to ensure the best use of your appointment time. Your success is important to us and is greatly dependent upon your commitment to consistent attendance and on-time arrivals. We also are committed to our therapists being timely for their appointments and if there is excessive tardiness or cancellations on behalf of our staff please do not hesitate to contact our office administrator.

2. ***Cancellations-*** We require a 24-hour notice for cancellations. After a one-time occurrence, a $25 fee may be charged for each missed therapy appointment. We know that sickness and other situations occur; therefore, if you think you may be sick or have a "life happens" event, please call us immediately to cancel and make every effort to reschedule. Appointments may be rescheduled within the same week to avoid being charged a cancellation fee.

   Unforeseen illnesses and accidents happen when least expected leaving no choice but to

cancel therapy on short notice. If your or your child becomes sick or injured, you may provide a physician's note verifying the illness/injury and you will not be charged.

The patient should not attend therapy if fever (100.4 degrees F or higher), diarrhea, or vomiting has occurred in the past 24 hours. We will be more than happy to reschedule your appointment when you recover.

Should your therapist become ill, or go on vacation, etc., you will be scheduled at your regular time with another therapist or notified and rescheduled when there is an available time slot. Please contact our office administrator with any concerns.

3. ***No Shows-*** If you or your child misses an appointment without contacting *Advanced Therapy Solutions, LLC*, you will be charged a no-show fee of $50. You may avoid a no show fee by rescheduling your appointment within 24 hours of the missed appointment. Insurance companies will not be billed for missed appointments. If you have 3 consecutive no shows we reserve the right to discharge.

4. ***Flex Scheduling-*** If you are unable to attend therapy at a regular recurring day and time we do offer flexible scheduling options. For more information regarding this option please speak with your therapist or our front desk team.

Section 4: Patient Rights

1. ***No Discrimination Policy-*** Patients have the right to equal treatment regardless of age, gender, race, sexual orientation, creed, religion, disability, or national origin.

2. ***Termination of Services-*** The patient may terminate services at any time throughout the course of treatment. Above cancellation policies apply if the patient does not cancel the session within 24 hours prior to the next scheduled appointment.

3. ***Personalized Therapy Goals-*** Patients and guardians have the right to propose treatment goals that are personally relevant and important to the patient's goals. Once suggested to the treating therapist, the therapist will assess the attainability and appropriateness and recommendations will then be made based on the therapist's professional clinical judgment.

Section 5: Communication with Physicians

1. To provide the highest quality of patient care, it is necessary for the therapists to have access to patients' medical charts and medical history. By signing Policies, Procedures, and Regulations Agreement, the patient or responsible party agrees to grant *Advanced Therapy Solutions, LLC* permission to contact their physician(s) and obtain pertinent medical information. *Advanced Therapy Solutions, LLC* may also share therapy documentation with physician(s) and insurance provider(s) if indicated for continuity of care and/or funding purposes.

Section 6: Liability

1. *Advanced Therapy Solutions, LLC* is not responsible for any claims or damages of any kind, for any injuries to any persons, and/or for any damages due to loss of property arising directly or indirectly from participation in therapy sessions.

Section 7: Our Promise

1. ***Therapist Maintenance of Licensure and Certification:*** The therapists at *Advanced Therapy Solutions, LLC* will evaluate and treat patients to the best of their knowledge and up to the standards as outlined in their professional Code of Ethics. Therapists shall meet or exceed the requirements for current state licensure and certifications held. Therapists at *Advanced Therapy Solutions, LLC* who practice therapy modalities that require additional certifications will actively maintain their certifications while practicing such treatment methods. Licenses and certifications will be posted publicly in the clinic for patient viewing.

2. ***Privacy Policy:*** *Advanced Therapy Solutions, LLC* will abide by current HIPAA standards. Patient files and patient information will be kept secured and confidential. Patient files and information will only be distributed as necessary to physician(s) or insurance provider(s) as stated in the document entitled, "Notice of Privacy Practices."

Effective Date: October 22, 2024

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Insurance & Policies Agreement

Patient Name: _____Date of Birth: _____/_____/_____

Insurance:

Primary Insurance	
Insurance Carrier:	Contract Number:
Name on Card:	Group Number:
Date of Birth:	SS#:

Secondary Insurance	
Insurance Carrier:	Contract Number:
Name on Card:	Group Number:
Date of Birth:	SS#:

Please check the appropriate box below:

I, the undersigned, ☐ certify ☐ do NOT certify that I (or my dependent) have insurance coverage with the entity(s) listed above and assign directly to **Advanced Therapy Solutions, LLC** all benefits from the above entity, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **Advanced Therapy Solutions, LLC** to release all information necessary to secure the payment of benefits.

By signing this form, I attest that I read, fully understand, and agree to the policies, procedures, and regulations as outlined in the document entitled "Advanced Therapy Solutions, LLC-Policies, Procedures, and Regulations" and will abide by these terms as written. I understand that changes to the provided policies, procedures, or regulations may be implemented at any time at the professional discretion of *Advanced Therapy Solutions, LLC* and notification will be provided.

_____ _____

Signature of Patient or Responsible Party **Date**

_____

Relationship to Patient

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Authorization to Release and Obtain Medical Information

Patient Name: _____Date of Birth: _____/_____/_____

The *Health Insurance Portability and Accountability Act* (HIPAA) mandates that all healthcare providers follow strict guidelines to maintain confidentiality and security of protected health information (PHI) when it is transferred or received. In order to release or obtain your medical/billing information to or from a third party, your written permission must be granted to *Advanced Therapy Solutions, LLC*. Without this authorization form, *Advanced Therapy Solutions, LLC* is not permitted to share your information with outside parties.

I, _____, grant *Advanced Therapy Solutions, LLC* permission to

Please check preference(s): ☐ Release ☐ Obtain

patient medical and/or billing information to the following individuals and entities along with other healthcare professionals and insurance companies as stated in the "Notice of Privacy Practices." I consent for the following persons and/or entities to consult with *Advanced Therapy Solutions, LLC*, via all means of communication, regarding my or my child's status in the areas of communication, behavior, health/medical, and academics.

Name/Entity:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

_____ _____

Signature of Patient or Responsible Party **Date**

_____

Relationship to Patient

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Permission to Leave Telephone Messages/ Wirelessly Transmitted information

Patient Name: _____Date of Birth: _____/_____/_____

Advanced Therapy Solutions, LLC therapists or staff members may occasionally need to contact patients or his/her responsible party for various notification purposes such as:

- Appointment reminders/confirmation/rescheduling,
- To address questions, concerns, and updates
- Requests to call the doctor

Without a patient's consent, we are unauthorized to leave messages on a machine or with household members, as this would result in a violation of HIPAA guidelines. We would like to know how we may contact you and with whom we can leave a message about your Protected Health Information. Please select your preferences below:

✓	Method	Individuals we may contact
	Cell Phone/Voice message	
	Home Phone/ Voice message	
	Work Phone/ Voice message	
	E-mail	
	Text Message	
	Other: (please specify)	

I authorize *Advanced Therapy Solutions, LLC* and/or staff to contact and send messages that could include Protected Health Information pertaining to the patient's care by the methods selected and with the above individuals.

_____ _____

Signature of Patient or Responsible Party **Date**

_____

Relationship to Patient

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Consent for Clinical Services

Patient Name: _____Date of Birth: _____/_____/_____

I, _____consent to the necessary consultation, evaluation, and/or clinical treatment of the patient (myself or my dependent) by the therapists doing business for *Advanced Therapy Solutions, LLC* as long as (I am/my dependent is) receiving services with this clinic. I consent to services that fall within the scope of the individual therapist's practice as defined by the State of Oklahoma and their governing association. I acknowledge that no guarantee has been made to me in regard to the result of evaluation and/or clinical treatment. In the unlikely event that emergency medical attention is needed (in the absence of a legal guardian or incapacitation of the patient), I give permission for such medical attention to be obtained.

By signing this form, I acknowledge that I have read and understand the contents and I am competent to execute it, or if executed on behalf of another I am authorized to execute it on behalf of that person.

_____ _____

Signature of Patient or Responsible Party **Date**

_____

Relationship to Patient