Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please Review it carefully.
The privacy of your health information is important to us.

Our legal duty
We are required by applicable federal and state law to maintain your privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

Patient rights: You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us at info@epictherapists.com. You have the right to request a list of certain types of disclosures of your information we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

Uses and Disclosures of Health Information
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide you.

Healthcare Operations: We may use and disclose your health information in connection with your healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you 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 written at any time. Your revocation will not affect any use or disclosure permitted by our authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your family and friends: We must disclose your information to you, as described in the Patient Rights section. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your payment for your healthcare, but only if you agree that we may do so.

Persons involved in care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to uses or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonable believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Acknowledgement of receipt of Notice of Privacy Practices: Please sign and print your name and provide the date below that you have had this Notice or Privacy Practices made available to you. Please sign this acknowledgement where indicated below and return it to the clinic staff.

Patient Health Information Designee (PHI): All information about you is confidential and will not be released to anyone unless you assign PHI designee.

Name: _____ Signature: _____ Date:

PHI Designee: _____ Signature: _____ Date:

Universal Consent for Treatment

I understand that my child(ren) condition requires outpatient care. I consent to and authorize testing; treatment and or hospital care as ordered by healthcare provider. I authorize clinic nurses, employees, volunteers and others as necessary to carry out the instructions of therapists with respect to the procedures and treatment they have ordered. I understand that it may be necessary for representatives of outside healthcare professional to assist in my child(ren) care.

During evaluation and treatment your child may be recorded for work sample or data collection purposes. I understand that work samples will be used for my child's treatment plan.

I have read and understand this information

Signature of patient, Parent/Guardian
Or legally Authorized Representative

Relationship to patient

Financial Policy

Thank you for choosing us as your speech therapist. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The follow is a statement of our financial policy which we ask you to read and sign prior to treatment.

Full payment is due at the time of services unless other arrangements have been made.

We accept cash or checks at this time.

Our insurance policy: If all insurance information provided is correct and kept updated by the patient, we will file your claim with your insurance company. However, your uncovered portion will be due at the time of service. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your bill within 30 days. You are responsible to pay the balance.

Please be aware that all services provide may not be covered by your insurance plan and may not be considered reasonable and customary as determined by your insurance company. It is your responsibility to know your insurance plan and covered services. If we have problems collecting payment from your insurance company, you may be asked to pay your balance at the time of service and get reimbursed from your insurance company.

Our office DOES NOT handle filing of secondary Insurance claims unless prior arrangements have been made and all information is given to us prior to processing primary insurance.

Outside evaluations:
We accept outside evaluations. If your child has been assessed in the area that needs treatment, evaluation fees will be waived. If your child needs additional assessment, evaluation fees will be applied.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is considered usual and customary for our area. You are responsible for any unpaid balances that your insurance company does not consider reasonable and customary.

Minor Patients
We request that all minors be accompanied by an adult at all times, unless requested not to. The adult accompanying the minor or the parent (or guardian) will be responsible for full payment unless other arrangements have been made with our office prior to the appointment.

Missed appointments.
Unless cancelled 24 hours in advance our policy is to charge $35 for missed appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, understand, and agree to this Financial Policy.

Name: _____ Signature: _____ Date: _____

PHI Designee: _____ Signature: _____

Media Release Consent Form (Optional)

This consent form will authorize Epic Therapists, LLC to use and print photographs and other forms of media materials for educational, informational, and promotional purposes. Images may be used, but not limited to, Epic Therapists newsletter, website, advertising material, etc.
This media release form will be kept by Epic Therapists, LLC as reference for individual approval.

Individuals Full Name: _____

Parent/Guardian's Full Name (if individual is under 18 years): _____

_____

Relationship to individual: _____

After reading the explanation above, I authorize Epic Therapists, LLC to take and use photographs or media in any Epic Therapists publication, production, or presentation, including electronic/internet marketing material for the purpose of promoting Epic Therapists in a positive manner.

Guardian/Individual Signature: _____

Date: _____