Synergy
FAMILY THERAPY SPECIALISTS
1700 Thomas Paine Pkwy
Centerville OH 45458
P: 937-428-6273
F: 937-428-6274

Photograph Release

I, _____, agree to allow Synergy Family Therapy Specialists, Inc. to take photographs of me and/or my child, which may be used for educational and learning purposes or promotional items.

I also forfeit any monetary fees or profits which may arise from presentations given by Synergy Family Therapy Specialists, Inc. using these pictures.

Patient: _____

Signature:_____

Witness: _____

Date: _____

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1700 Thomas Paine Pkwy
Centerville OH 45459
937-428-6273

Billing and Collection Policies

We welcome you as a new patient of Synergy Family Therapy Specialists. To keep you informed of our current office and financial policies we ask that you acknowledge, with your signature, having received our Policies and Procedures. Please keep this document for future reference.

Insurance

PLEASE CONTACT YOUR INSURANCE COMPANY TO VERIFY YOUR BENEFITS. We will verify your insurance for you. Please note that when we verify benefits, we are simply relaying information obtained from your insurance company and Synergy Family Therapy Specialists is NOT responsible for any erroneous information they might provide. (Please see "Patient Insurance Verification Questionnaire".)

For insurance plans that we contract with, that require copays, the copay must be paid prior to any services being rendered. The copay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. Because of federal regulations, we are unable to extend courtesy or professional discounts to anyone, or to waive copays or deductibles. Any deductible and coinsurance amounts will be determined as you progress with your care.

Payment for any coinsurance, deductibles, or non-covered service as required by your insurance is expected at the time of service. **A receipt will be issued at that time, which will be your proof of payment. Proof of payment will be required when disputing whether or not a copayment was made at the time of service.**

You will receive an Explanation of Benefits (EOB) from your insurance company indicating what they have paid and your financial responsibility. Any remaining balance is due upon receipt of that EOB. Please send this amount immediately to our remittance location at: Synergy Family Therapy Specialists, Inc., 1700 Thomas Paine Pkwy., Centerville, OH 45459. Any portion of your bill that is your responsibility will be billed to you after receipt of payments from your insurance company.

Cash-Pay

For patients who do not have insurance coverage, or have exhausted their physical therapy benefits, we offer a cash discount if paid at the time of service. Cash-pay services cannot be billed to your insurance. We provide this option to make your healthcare accessible and affordable.

We accept cash, check, MasterCard, VISA, and Discover. There will be a fee of $40 charged on all returned checks.
Again, we welcome you as a physical, occupational, and speech therapy patient, and will be happy to answer any questions you may have on the above policies.

Initial Disclosure

(This concerns any part of an account that reaches an age of 90 days or older from the time of service). In order to keep overhead costs to a minimum, there will be a 90 day period from the time service is rendered in which a bill may be paid without the addition of any FINANCE CHARGES. At that point in which any part of the balance becomes 90 days old, a FINANCE CHARGE will be assessed. The FINANCE CHARGE is 1.5% per month (periodic rate) which is 18.5% ANNUAL PERCENTAGE RATE. We figure (a portion of) the FINANCE CHARGE on your account by applying the periodic rate to the "90 DAY" part of your account. The "90 DAY" part of your account is arrived at by added together the amounts from the previous month that appear in the "60 DAY" and "90 DAY" columns of your bill (which is to say, any part of your account that is 60 days or older from the previous month), and subtracting from that column any payments or credits posted during the course of the present billing cycle. All account balances over 120 days will be turned over to an outside collection agency. A 25% collection fee may be added to your account balance if outside collection efforts are needed. Any previous account balances must be paid in full prior to receiving additional services.

If you think your bill is wrong, or if you need more information about a transaction on your bill, contact us at 1-937-428-6273.

We must hear from you no later than 30 days after we sent you the first bill in which the error of the problem appeared.

You do not have to pay the amount in question while we are investigating, but you are still obligated to pay the parts of your bill that are not in question. While we investigate your question, we cannot report you as delinquent or take any action to collect the amount you question.

PLEASE NOTIFY FRONT DESK OF ANY CHANGES IN YOUR INSURANCE AND PRESENT NEW INSURANCE CARDS

_____

Parent's Signature & Date

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Patient Cancellation/No Show

It is important for you to attend your therapy sessions, in order to allow you or your child to make the most progress possible.

Synergy Family Therapy Specialists requests that any cancellations of appointments be made at least 24 hours in advance. The reason for cancellation, if provided by the patient, is noted in the patient's chart. Patients who fail to cancel 24 hours before their appointment will be subject to a $50 cancellation fee, per appointment. Synergy Family Therapy Specialists is willing to waive the cancellation fee if the patient reschedules their appointment, or at the discretion of the therapist. We have been lenient with our cancellation policy in the past, but will be enforcing it moving forward, as our overall goal of rescheduling appointments is to make sure that our patients continue to make adequate progress with intervention, to reach their goals.

Patients who fail to show for appointments are contacted as soon as possible after the scheduled appointment and prior to the next scheduled appointment. The purpose of this is to verify attendance for the next appointment and to educate the patient on the need for proper compliance with the treatment program. Patients who fail to attend their regularly scheduled appointments may be subject to removal from the therapist's permanent schedule after the second missed appointment. Your permanently scheduled appointment may be subject to removal from the therapist's permanent schedule, if frequent cancellations, including advanced cancellations, are made.

The referral source may be notified if the patient fails to show for appointments or is frequently non-compliant with their appointments. This is done through the regular progress report or through a no show/cancel form completed by the office secretary. These reports are generated on an as-needed basis.

Sibling Policy

At Synergy Family Therapy Specialists, we believe siblings can be a great motivator during sessions. If you bring siblings to therapy sessions, we ask that they are supervised by you or a designated adult at all times, as our main focus will be on your child receiving services. In the event that a sibling(s) becomes a distraction to the therapy session or to others, we may ask that you and your child(ren) wait in the family waiting room for the remainder of the session. If you feel that a sibling is no longer focused on assisting during a session and maybe taking away from the progress of the child, we ask that you intervene. Children not receiving therapy services must be supervised at all times and should never be left unattended while on Synergy Family Therapy Specialists' property. Thank you for your understanding.

_____

Parent's Signature & Date

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date: _____

I. **THE PATIENT**. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: _____
Date of Birth: _____
Social Security Number: _____

II. **AUTHORIZATION**. I authorize Synergy Family Therapy Specialists to use or disclose the following: (check one)

☐ - All of my medical-related information.
☐ - My medical information ONLY related to: _____
☐ - My medical-related information from _____ to _____
☐ - Other: _____

Hereinafter known as the "Medical Records."

III. **DISCLOSURE**. Synergy Family Therapy Specialists has my authorization to disclose Medical Records to: (check one)

☐ - Any party that is approved by the Authorized Party.

☐ - ONLY the following party:
Name: _____
Address: _____
Phone: _____ Fax: _____
E-Mail: _____

IV. **PURPOSE**. The reason for this authorization is: (check one)

☐ - **General Purpose**. At my request (general).

☐ - **To Receive Payment**. To allow the Authorized Party to communicate with me for marketing purposes when they receive payment from a third party.

☐ - **To Sell Medical Records**. To allow the Authorized Party to sell my Medical Records. I understand that the Authorized Party will receive compensation for the disclosure of my Medical Records and will stop any future sales if I revoke this authorization.

☐ - **Other**: _____

V. **TERMINATION**. This authorization will terminate: (check one)

☐ - Upon sending a written revocation to the Authorization Party.
☐ - On the following date: _____
☐ - Other: _____

VI. **ACKNOWLEDGMENT OF RIGHTS**.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____

Print Name: _____

IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW

The patient is unable to sign due to: (check one)

☐ - **Being a Minor**. Patient is [#] years old and considered a minor under state law.

☐ - **Being Incapacitated**. Patient is incapacitated due to: _____

☐ - **Other**: _____

Signature of Representative: _____ Date: _____

Print Name: _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: _____

ADDITIONAL CONSENT FOR CERTAIN CONDITIONS

I. **SENSITIVE INFORMATION**. This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released. (check one)

☐ - **I consent** to have the above information released.

☐ - **I <u>do not</u> consent** to have the above information released.

Signature of Patient: _____ Date: _____

Print Name: _____

II. **HIV/AIDS**. This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released. (check one)

☐ - **I consent** to have the above information released.

☐ - **I <u>do not</u> consent** to have the above information released.

Signature of Patient: _____ Date: _____

Print Name: _____