THERAPEUTIC SOLUTIONS of NC

Serving to Improve Quality ofLife!

Consent to Treat and Patient Information Consent Form

CONSENT TO TREAT

The patient authorizes the Occupational Therapist to examine and treat the condition as he/she deems appropriate through the use of occupational therapy measures, and the patient gives the authorization for these procedures to be performed. The patient has the right to informed participation in decisions involving his/her health care. This shall be based on clear, concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects as well as the probability of success with such procedures shall be disclosed to the patient by his/her attending Occupational Therapist. The patient will not hold the Occupational Therapist responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. The patient has the right to know who is responsible for authorizing and performing any and all treatment procedures. The patient shall not be subjected to any procedure without his/her voluntary, competent, and understanding consent or the consent of his legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed. The patient shall be advised if Therapeutic Solutions proposes to engage in or perform human experimentation, for the purpose of research, affecting his/her care. The patient has the right to refuse to participate in such research projects. After reading the above (or having it read to me), I hereby consent to receive occupational therapy services from Therapeutic Solutions to begin on this date and terminating when determined by myself, my physician or my Occupational Therapist.

PATIENT INFORMATION CONSENT

I have read and understand Therapeutic Solution's **Notice of Client Information Practices**. I understand that the company may use or disclose my personal health information for the purposes of carrying out treatment, referring to another provider for treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the company. I also understand that the Company will consider requests for restrictions on a case by case basis but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in the Company's **Notice of Client Information Practices**. In doing so, I hereby release **Therapeutic Solutions** from any and all legal liability that may arise from the release of such information. I agree that a copy of this authorization may be used in place of the original. I understand that I retain the right to revoke this consent by notifying the Company in writing at any time except for that action which has already been taken. It shall be effective only long enough to answer the purpose of which it is given, and no further confidential information will be released without the execution of an additional written authorization.

Client and/or Parent/Guardian's Printed Name if Client is under 18:	List of persons we can speak with regarding your personal health information and emergency contact
______________________________ Printed Name Signature ______________________________	1. ______________________________ 2. ______________________________ 3. ______________________________ 4. ______________________________

Is the client receiving Home Health services? YES NO

Client's demographic information has been verified. YES NO

Therapist Signature______________________________

Client Signature______________________________

100 Parkway Office Court – Suite 202, Cary, NC 27518–- Office: 919-239-4805 // Toll Free FAX: 855-497-8443
therapeuticsolutionsofnc.com

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ASSIGNMENT OF BENEFITS / CANCELLATION / DISCONTINUANCE FORM

Client's Name:_________________ ___________________ Date: __________________

ASSIGNMENT OF BENEFITS

I_________________________________understand that my insurance company will be sent an itemized bill for each session in accordance to reasonable and customary charges. I agree to assign benefits directly to Therapeutic Solutions of NC for all therapy services rendered. I also agree to remit any monies sent to me in error from my insurance company for services rendered to Therapeutic Solutions of NC. I agree to pay for all services rendered should my insurance company deny payment for services rendered, and will be responsible for any deductible, co-insurance or co-payment, to be paid at the time of my visit. Therapeutic Solutions of NC reserves the right to cancel treatment if payment for services is not received, and to use whatever means necessary including an attorney, small claims court, or collection agency in an attempt to secure payment.

CANCELLATION and DISCONTINUANCE FROM SERVICES POLICY

This office requires 24 hours notice for cancellations. Otherwise, you will be charged the full fee of the session. In addition, you will be charged the full fee for the session if you do not show for a confirmed appointment. Should you miss three consecutive visits it will be considered that you are not in adherence or compliance with your plan of care, and will be discharged from this office. Your primary physician will be notified and you will be given the names of three like professionals for your future use should you decide to begin therapy services again.

Cancellation Fee (less than 24 hours) $ 50
No Show Fee $ 50
Non-Sufficient Funds Fee $ 25
Cancelled/Stopped Check Fee $ 25
Late fee (for each 15 minutes) $ 15

I have read and agree to the above policies and procedures.

Client and/or Responsible Party Signature__________________________________

Date_____________________________________

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ADVANCE BENEFICIARY NOTICE

Client's Name:________________________________Medicare # / Insurance # _______________________

ADVANCE BENEFICIARY NOTICE (ABN)
NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare/Insurance will not pay for the item(s) or service(s) that are described below. Medicare/Insurance does not pay for all of your health care costs. Medicare/Insurance only pays for covered items and services when Medicare/Insurance rules are met. The fact that Medicare/Insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor has recommended it. Right now, in your case, Medicare/Insurance will probably not pay for:

Name of Service:

Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don't understand why Medicare/Insurance probably will not pay.
- Ask us how much these services or items will cost (Estimatedcost: $__________) in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE ONE OPTION. CHECK ONE OPTION. SIGN AND CHECK YOUR CHOICE.

_____OPTION 1. Yes. I want to receive these items or services. I understand that Medicare/Insurance will not decide to pay unless I receive these items or services. Please submit my claim to Medicare/Insurance. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare/Insurance is making a decision. If Medicare/Insurance does pay, you will refund to me any payment that I made to you that are due to me. If Medicare/Insurance denies payment, I agree to be personally responsible for payment. That is, I will pay personally either out of pocket or through any other insurance that I have. I understand that I can appeal Medicare/Insurance's decision.

______OPTION 2. NO. I have decided not to receive these items or services. I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare/Insurance and that I will not be able to appeal your opinion that Medicare/Insurance won't pay.

________________________ ____

Date Signature of Client or Person Acting on Client's Behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. If your claim is submitted to Medicare/Insurance, your Health information on this form may be shared with Medicare/Insurance. Your health information which Medicare/Insurance sees will be kept confidential by Medicare/Insurance.

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