Terms of Payment Agreement

This is not an online form. Please print the form, fill it out and bring it to your appointment.
Thank you!

We reserve regularly scheduled appointments for our clients. In consideration for all clients we start and end the sessions at the regularly scheduled time and appreciate our families' cooperation in this policy. We believe that children who come consistently to therapy make the most progress, however, we do understand that there are times it is necessary to cancel a session. We ask for 24 hours notice if you find you cannot make your appointment. Last minute cancellations (i.e., less then twelve hours before the designated appointment) and /or no calls, no shows will be billed for the treatment session missed and the invoice will reflect that information appropriately. Exceptions to the cancellation policy will be made for children who are ill upon awakening only if notice is received by 8 am. Therefore, please call and leave a message at the office first thing in the morning if your child is sick. If you wait until right before the appointment to call and cancel, you will be billed for the missed appointment. If weather is bad we will be contacting you to discuss arrangements, or if you know you cannot get here, call and leave a message on your therapists' voice mail.

Phone conversations with therapist discussing your child are billed in quarter hour increments starting after the first quarter hour.

Payment is due at the time of service, unless you have made other arrangements with our accounting office. We accept VISA, MasterCard or personal Checks.

I understand that health insurance policies and reimbursement are between myself and the health insurance company. That all services rendered by Myania Moses and Associates for the below referenced individual are charged directly to me, and I am personally responsible for payment in full to Myania Moses and Associates. I understand that if payment in full is not received by Myania Moses and Associates within ten days of invoice date that Myania Moses and Associates, will assess a five percent (5%) late charge on such outstanding balance. I understand that if my outstanding balance due to Myania Moses and Associates for the treatment of the above reference individual becomes Five hundred Dollars ($500) or more, Myania Moses and Associates reserves the right to withhold therapy up to and until such balance is paid in full. I understand that I will be responsible for all legal fees and collection fees with Myania Moses and Associates and may incur if payment is not made in accordance with the terms and conditions hereinabove. I understand that agreements regarding fee schedules and charges for canceled appointments are my responsibility and not the responsibility of my health insurance company, if any.

I_____,acknowledge and accept full and complete responsibility for prompt payment of all services rendered to

_____by Myania Moses and Associates, I acknowledge that prompt payment is due at time of treatment, unless I have made arrangements for monthly credit card billing. I have received written explanation of the fee schedule and the cancellation policy and I agree to both.

_____ _____
Signature of Parent/Guardian Date

Myania Moses & Associates Credit Card Authorization

This is not an online an online form, fill it out and bring to your appointment. Thank you!

Child's Name_____

We ask for 24 hours notice if you find you cannot make your appointment. Last minute cancellation (i.e.: less then twenty-four hours before the designated appointment) and/or no calls, no show will be billed for the treatment session missed and the invoice will reflect that information appropriately. Exceptions to the cancellation policy will be made for children who are ill upon awakening only if notice is received by 8 am. Therefore, please call and leave on your therapists' voice mail if your child is sick. If you wait until right before the appointment to call and cancel, you will be billed for the missed appointment.

By signing below you confirm that you fully understand that health insurance policies and reimbursement issues are between you and your health insurance company, that all services rendered to your child are charged directly to you and that you are personally responsible for payment to Myania Moses and Associates and this responsibility is not related to potential health insurance coverage or reimbursement.

The undersigned authorizes Myania Moses and Associates, to make the following charges to their credit card for payment of occupational therapy services and /or associated expenses.

CREDIT CARD NUMBER_____

VISA or MASTERCARD ONLY

EXPIRATION DATE_____

3 DIGIT CODE _____

NAME ON THE CARD _____

AS IT APPEARS ON THE CARD

SIGNATURE OF CARD HOLDER_____

DATE_____

ADDRESS THE CARD STATEMENTS ARE MAILED TO (BILLING ADRESS)

_____

ZIP CODE _____

This information must match the card or it will not process. We request that you notify our office as soon as possible if any of this information changes. This agreement will remain in effect, and your card may be charged monthly, until this agreement is cancelled in writing.

Myania Moses and Associates

CONSENT FORM AND NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

This is not an online form. Please print the form, fill it out and bring it to your appointment. Thank you!

I have received, read and understand your Notice of Privacy Practices.
I understand that Myania Moses and Associates has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at its office to obtain a current copy of the Notice for Private Practices.

I, _____, give my permission to Myania Moses and Associates to exchange information with the following physicians, programs or other persons, list below:

_____

_____

_____

about,_____,
whose date of birth is_____.

Please check boxes below:

☐ I understand that my Invoice for services will be emailed to the address I provide unless otherwise specified.

☐ I give permission for Myania Moses and Associates to provide evaluations, treatment, and consultative services to the above mentioned client. I understand that any electronic communication (e.g., email) initiated by myself is granting permission for Myania Moses and Associates to communicate via email.

_____
(Guardian Name Printed)

_____
Relationship to Client

_____
Signature

_____
Date

OFFICE USE ONLY
I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices acknowledgment, but was unable to do so as documented below:
Date:_____Initials_____Reason_____
Staff signature: _____

Billing/Insurance Information

If you are planning on submitting to your insurance company for reimbursement, please fill out the following, so we can put the pertinent information on your monthly statement.

Child's name: Pediatrician:

Mother's name: Pediatrician's phone:

Father's name:

Address:

Home phone:

Mother's work phone: Father's work phone:

If you are submitting to insurance please be sure that we have a copy of the prescription on file.

Insurance company:

Insurance company phone number:

Insurance company address: Contact person:

Policy holder name: Policy number:

Please provide SS #'s only if needed

Policy holder:

Child:

Thank you for your cooperation Myania Moses and Associates

HIPAA POLICY
NOTICE OF PRIVACY PRACTICES
(MEDICAL)
RULES UPDATED AS OF SEPTEMBER 2013
Changes are noted in bold.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. ****You have the right to opt out of any communication regarding health-related benefits and services, as well as fund-raising opportunities.**

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

1. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
2. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
3. **The right to request restriction of disclosure of personal health information, if the disclosure is for payment or health care operations and pertains to service for which the individual has paid out-of-pocket in full.
4. **The right to electronic copies of health information as used by this office. We currently do not participate in electronic record keeping.
5. The right to inspect and copy your protected health information.
6. The right to obtain a paper copy of this notice from us upon request.
7. **The right to notification of a breach of unsecured personal health information.

This notice is effective as of September 2013 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the polices and procedures of our office. We will not retaliate against you for filling a complaint.

Please contact the following for more information:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

This signature indicates I have received, and read, the updated HIPAA (2013) Notice of Privacy Policies.

_____ _____,20__

Office use only:

The client was given NPP but refused to sign as requested:

_____ _____,20__
Staff signature (required)

MYANIA MOSES & ASSOCIATES EMERGENCY CARE

I_____
Parent/Guardian of

_____
Son/daughter
Born on _____, do hereby give my consent to
Myania Moses and Associates

_____
To secure such emergency medical treatment as the above name might require while under the supervision said care provider.

The staff of Myania Moses and Associates agrees to notify the Parent/Guardian whenever this child becomes ill, and the Parent/Guardian agrees to make arrangements to use his/her family physician and if unavailable to contact said physicians to make arrangements to use facilities as necessary to meet the emergency. The Parent/Guardian agrees to indemnify and hold harmless Myania Moses and Associates against my claim, demand, debt, obligations, liability, cost, expense, right of action or cause of action based on arising out of such emergency. In the event the Parent/Guardian is not on the premises/reachable Myania Moses and Associates has my permission to implement emergency action/care.

Parent/Guardian_____Date_____
Child/Children_____
Physician_____Telephone#_____
Preferred Hospital_____

Insurance Information
Name of Subscriber_____
Insurance Company_____
Group #_____
ID#_____
Social Security #_____

Emergency Contact Information
Home_____ m/cell_____
Dad/work_____d/cell_____
Emergency contact person_____
Emergency Contact Person's Telephone #_____
Relationship_____