Niagara Therapy, LLC
General Office Policies

Patient Name(s): _____ # _____

Initial evaluation and regular appointment _____(initials)

-Please arrive 30 minutes early for your first appointment (20 minutes if you complete paperwork before arrival). Bring with you: pertinent prior medical records including prescription, your medication list, your photo ID, your insurance cards, a patient information form, and the patient history form that has been emailed to you with this form. Please bring someone that is able to speak for you or with you (and can legally sign for you) if you have limitations in your ability to complete forms independently or struggle with understand complex information (verbally or written).

Appointments will be scheduled on a first come first-served basis. We always attempt to accommodate your preferred times and days as much as possible. We appreciate your flexibility in attending on occasion at a less preferred time. Please arrive approximately 5 minutes before your scheduled appointment. If you are late, please be aware that appointments may have to be rescheduled. All cancellations and no-show appointments will be documented in the medical record and are available to all payor sources.

If you are unable to make an appointment, please notify us 24 hours in advance (on the prior *business* day) of your therapy time by calling 814-464-0627. A missed appointment is any appointment that is missed without 24 hours advanced notice. All missed appointments must be rescheduled within seven calendar days to avoid a $25 missed session fee. Please be aware that this may require an appointment at a less preferred time and missed appointments should be avoided when possible.

> For example, if you will be missing a Monday 11 AM appointment, you must call and cancel the appointment before 11 AM on Friday or reschedule the appointment before the following Monday. If the appointment is not canceled by 11 AM Friday or rescheduled by the following Monday, a $25 fee will be assessed to your account.

It is crucial to value your time in therapy as missed appointments restrict you from achieving your goals and restrict other clients from achieving their goals as that time was reserved for you.

Minors _____(initials or NA)

Any client under the age of 18 must be accompanied by a legal parent or guardian to the initial appointment. Minors will be released to the parent or adult who brought them to the therapy appointment for regular scheduled appointments (unless other arrangements are communicated to the office staff at the start of the session). Please be prompt for pick up as this interferes with another appointment and communication of session will be limited.

Notice of Privacy Policies and Rights/Responsibilities _____(initials)

Niagara Therapy, L.L.C. will use and disclose your personal health information to treat you and receive payment for the care and services provided. There is a prepared Notice of Privacy Practices to help you understand the policies about your personal health information. The terms may be changed without notice. A copy of this notice is available for you at any time. Niagara Therapy, L.L.C. has a document that outlines the rights and responsibilities of every patient that receives care. The terms may be changed without notice. The notice is available to you at any time. A complete medical history has been provided to Niagara Therapy, L.L.C. It is understood that to reach maximum rehabilitation, the patient must follow the physician's prescribed treatment and the treatment plan established with the therapist.

After hours, emergencies, weekend issues _____(initials)

If an issue arises, please call the office and feel free to leave a message. We will return your call on the next business day. If you have a life-threatening situation, call 911 or go directly to the emergency room.

Telehealth Services _____(initials)

This is designed to allow you to give informed consent for the use of video technology for online therapy. Online therapy or teletherapy is defined as the use of technology to have a therapy session. We will use thera-LINK, a HIPAA compliant platform that uses video and audio technology through a webcam on your device and my device to connect us securely. Please visit www.thera-Link.com for details.

The benefits of teletherapy include the convenience of location, time, wait times, and accessibility which allows for better continuity of care. In addition, teletherapy allows for greater accessibility to services for clients with limited mobility or with lack of transportation. Teletherapy can also allow for couples or families to meet when in different locations. The coverage of virtual therapy or telehealth is dependent on each insurance plan. It is the responsibility of each patient to ensure the coverage of their plan.

With all technology, there are also some limitations. Technology may occasionally fail before or during our session. The problems may be related to internet connectivity, difficulties with hardware, software, equipment, and/or services supplied by a 3rd party. Any problems with internet availability or connectivity are outside the control of the therapist and the therapist makes no guarantee that such services will be available or work as expected. I agree to take full responsibility for the security of any communications of treatment on my own computer and in my own physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my user ID to access the Services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation. I understand that there will be no recording of any of the session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law. I understand that I am not allowed to do any recording, screenshots, etc. of any kind, of any session, and are grounds for termination of the client-therapist relationship.

Animal Assisted Therapy and Therapy Student Participation _____(initials)

I understand and acknowledge that Niagara Therapy, LLC may utilize the services of a certified therapy dog/facility canine in my treatment. I fully understand the risks involved with the use of a service dog as part of my treatment regimen and I fully accept all of those risks, including, but not limited to, bites, nips, scrapes, punctures and/or any other injury or damage which I may sustain as a result of my interaction with the dog. Further, I release Niagara Therapy, LLC and the Erie Humane Society from any and all claims I might have against either of them as the result of my interaction with the dog. At any time, preference can be requested to not allow animal assisted therapy involvement in the therapy assessment and/or intervention. Please voice this request to any staff member.

Niagara Therapy, LLC acknowledges that therapy services are a skilled service and learning that skill is challenging. It is the practice of Niagara Therapy, LLC to offer placement for students in therapy programs. Interventions are completed within the ethical and legal parameters of safe student supervision. A student will always make their presence known as a “student” or “intern” to potential clients or guardians. At any time, preference can be requested to not allow a student involvement in the therapy assessment and/or intervention. Please voice this request to any staff member.

Photography/Video of Sessions _____(initials)

Photography and/or video may be used by staff for therapeutic purposes and destroyed after clinical use. Photography and/or video taken by clients/family/caregivers may be appropriate, but consent must be completed with all parties in advance and completed in a private treatment space.

Acknowledgement of Risk _____(initials)

COVID-19. The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious resulting in symptoms that may be mild to symptoms that may result in death. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing, frequent hand-washing and masking where possible. The Released Parties have put in place preventative measures aimed at reducing the spread of COVID-19; however, they cannot guarantee that you will not become infected with COVID-19 while participating in any service at Niagara Therapy, LLC. Further,

participating in care at Niagara Therapy, LLC may increase your risk and your child's risk of contracting COVID-19 or any other illness/virus.

ASSUMPTION OF RISK: I have read and understood the above warning concerning COVID-19. I hereby choose to accept the risk of contracting COVID-19 or any other illness/virus for myself and/or my minor child in order to utilize programing offered by the Niagara Therapy, LLC. These programs are of such value to me and/or to my child, that I accept the risk of being exposed to, contracting, and/or spreading COVID-19 or other illness/virus in order for me and/or my minor child to participate in programming.

WAIVER OF LAWSUIT/LIABILITY: I hereby forever release and waive my right to bring suit against Niagara Therapy, LLC in connection with exposure, infection, and/or spread of COVID-19 or other illness/virus/injury related to participating in programming operated by Niagara Therapy, LLC. I understand that this waiver means I give up my right and my minor child's right to bring any claims including for personal injuries, death, disease or property losses, or any other loss, including but not limited to claims of negligence and give up any claim I or my minor child may have to seek damages, whether known or unknown, foreseen or unforeseen.

COMPLIANCE WITH SAFETY GUIDELINES: I or my minor child will comply with all such orders, directives, and guidelines while participating in the program, including, without limitation, requirements related to hand sanitation, social distancing, and use of face coverings. I or my minor child will also follow all instructions of Niagara Therapy, LLC and/or while participating in care. I or my minor child agree not to attend the program if I or my minor child is experiencing symptoms of the COVID-19 or tests positive.

Insurance, payments, and financial issues _____(initials)

-Niagara Therapy, L.L.C. will bill your insurance carrier solely as a courtesy to you. **You, the patient/responsible party, are responsible for the entire bill as services are rendered.** Arrangements for your portion of the bill must be made today. If your insurance company does not dispatch payment within 60 days, the balance in full will be due from you. In the event that your insurance company demands a refund of payments made to Niagara Therapy, L.L.C., you will be responsible for all monies refunded to your insurance company. If your insurance company places an internal usual and customary fee schedule into place, you will be responsible for the balance remaining. In the event that payment is made to you that was billed by Niagara Therapy, L.L.C, you recognize the obligation be promptly forwarded to Niagara Therapy, L.L.C. If your balance is forwarded to a collection agency, you are responsible for 30% and interest charges/fees. Your payment is expected in the form of cash or check at the time of service. If credit card/debit card/FSA/etc. payment is used, it will have a convenience fee of $5.00.

-Please check with your insurance company prior to your visit to ensure that we participate in your insurance plan, your diagnoses are covered, and to determine what, if any, costs will be associated with your visit. We bill your insurance as courtesy, the financial responsibility of the session is ultimately your responsibility. It is your responsibility to contact your insurance company for estimated costs for therapy evaluation and treatment sessions. The final determination of cost will be made on the insurance explanation of benefits.

- I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and any other third-party payors to Niagara Therapy, L.L.C. A photocopy of this document is to be considered as valid as the original. I authorize Niagara Therapy, LLC to release all information necessary, including medical records, to secure payment.

-All insurance related payments are established by the insurance company and are unable to be disputed by this office. If you have a question in regard to your insurance coverage, please call the number on the back of your insurance card directly. As per Niagara Therapy LLC's contract with insurance companies, we are required to collect all co-pays, co-insurances, and deductibles. Many insurance companies have added additional coinsurances and deductibles to their plans. Please be prepared as these payments will be due either at the time of service (when possible, an estimate will be billed at the time of service and balance billed after the insurance processes the claim) or when billed if they require processing by the insurance company first. If your insurance denies payment for services rendered for any reason, you are responsible for all charges. The following will be completed at the evaluation and any change of insurance (we will complete this portion at the first appointment):

The insurance verified benefits that leave out of pocket responsibility to you. At each session you are responsible for $_____ per service ($_____ per service evaluation). ____ You will be invoiced.

___ You have a copay. Copays are flat amounts and due at every appointment.

___ You have a deductible. Deductibles are out of pocket cost that must be paid by the patient before the insurance covers any part of the claim. An upfront charge of $200/evaluation, $100 one hour, and $60 half hour is due on the day of service if there is a deductible on the insurance verification. After the insurance processes claims, the balance reported due by the explanation of benefits will be invoiced (for example, if the insurance processed a one-hour session for $125, the invoice would reflect the $100 payment and $25 outstanding due). Invoices are due on receipt.

___ You have a coinsurance. Coinsurance is a percent of the charges are left to the patient. Your coinsurance is ___% and this will be invoiced. Invoices are due on receipt.

***This is not a guarantee of payment and amount due. The final amount due is determined at the time the insurance processes the claim. If you disagree with the amount, payment must be rendered to Niagara Therapy, LLC and you have the right to proceed with patient appeals with the insurance provider. This is the patient responsibility. This estimation was provided by the insurance company. Niagara Therapy, LLC completes this as a courtesy and does not guarantee the accuracy. *** _____(initials)

-If your insurance is through Worker's Compensation or a motor vehicle accident, you must provide the name of the carrier, claim number, date of injury, contact person, phone number, and mailing address of the insurance company. We also require your medical insurance as a backup if the claim is denied or unable to be processed through Worker's Compensation or motor vehicle insurance. Be advised that if your claims are denied for any reason, you will be held responsible for the total amount of the charges for services rendered. This is not a guarantee that services will be covered by medical insurance. Ultimately, the financial responsibility is that of the patient.

-If payment is made by check and the check is returned for any reason, the original bill and a $30 fee must be paid in full before any further services will be provided. It will then be the discretion of Niagara Therapy, L.L.C. as to the further forms of payment for future and additional services.

-At the end of the month any and all outstanding balances will be charges to the following credit card (with a convenience fee of $5.00). A card must be placed on file. There will be no charges on the card if coordination of payment is completed PRIOR to the last day of the month. I authorize any and all balances to be charged monthly to the following card:

Number:_____ Exp _____ Security Code:_____ Billing Zip:_____

Signature of card holder:_____

Consent for Care and Treatment

I, the undersigned, herby agree and give my consent for Niagara Therapy, L.L.C. to provide medical care and treatment to myself or the party listed as the patient that is considered necessary and proper in diagnosing and/or treating the physical/mental etc. condition. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through Niagara Therapy, LLC at any time. I am free and encouraged to ask question at this time and as therapy continues. I acknowledge that I received and understand this copy of the general office policy practices of Niagara Therapy, LLC. By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. If signing on behalf of someone, I certify that I am the legally responsible party for the named patient. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Signature of client, parent, or guardian: _____ Date: _____

Name of signing and responsible party: _____ Relationship (if not client) : _____