



Ability Occupational Therapy Services, LLC

HOURS OF OPERATION
"8:00 AM TO 5:00 PM"
MONDAY THROUGH THURSDAY

PATIENT AGREEMENT

Ability Occupational Therapy Services, LLC offers **Occupational Therapy** services for patients referred to our practice. We are a licensed provider who develops individualized treatment plans to identify the services that will best suit your therapy needs. We work with your primary care practitioner to coordinate your care, please ask your primary care provider to send us a referral for your initial assessment.

Following your initial assessment visit(s), we develop a specific plan of care for review and approval by your referring provider.

Medicaid requires that a physician, physician's assistant, or an advanced nurse practitioner review this Plan of Care and return it to our practice within 14 days. We are pleased to serve your occupational therapy needs and encourage your feedback to alert us to anything we can do to meet the needs of your child. Ability Occupational Therapy Services, LLC will work collaboratively with the client / child's family / caregiver / guardian on concerns and or needs expressed by you and requests family / guardian / caregiver involvement in the home programming.

We require certain information from each patient in order to begin your care. The attached forms need to be completed in order for us to get you started as our patient. Please do your best to complete all the information. If certain information does not apply to you, please indicate that by noting "N/A" ("Not Applicable") so that we know that you did not overlook anything.

VACCINATION POLICY (EFFECTIVE DATE – SEPT. 19TH, 2019)

Please be aware of AOTS' LLC new policy regarding vaccinations. This new vaccination policy is due to the safety issues given the nature of the patient's we serve and is not based on any other reason nor is it meant to pressure patients into getting vaccinated.

Upon initial phone call, each family will be asked if the patient has been vaccinated. If the answer is no, we will make our best effort to work with the patient and their family to locate a provider who is able to provide treatment. For current patients who are determined to not be vaccinated, we will continue providing services for thirty (30) days, to allow the family time to transition to another provider.

As an occupational therapy practice that serves patients that are infants through young adulthood with vulnerable medical conditions and/or with complex medical needs, we are committed to the protection of all our patient's health and well-being. We choose not to put vulnerable patients at risk and therefore will not see patients who are unvaccinated. This policy applies regardless of the reason for your decision not to vaccinate.

MEDICAID & PRIVATE INSURANCE

CO-PAYMENTS, DEDUCTIBLES AND NON-COVERED SERVICE

Each healthcare insurance payer has different guidelines for allowing coverage of Ability Occupational Therapy Services, LLC. Some policies do not cover this service, others have limited visits, and some limit the types of diagnosis that are covered. We highly recommend that you contact your insurance a carrier prior to beginning services to discuss the coverage available to you for your child. If your healthcare insurance payer does not cover Ability Occupational Therapy Services, LLC, you are welcome to make self-pay arrangements with our Billing Agent.

PROOF OF GUARDIANSHIP

Ability Occupational Therapy Services, LLC requires official documentation from the guardian / foster care home of proof of guardianship and consent for emergency medical care and or for routine medical care.

CANCELLATION POLICY

If you need to cancel we ask that you call at least 24 hours in advance, otherwise this will be considered a "No Show". Exceptions are understood if your child suddenly becomes ill. Please do not bring your child with a green runny nose, a fever, or if they vomited within the last 24 hours. Appointments are in high demand and your early cancellation will give another person the possibility to schedule.

NO SHOW POLICY

A "No Show" is someone who misses an appointment without calling 24 hours in advance to cancel. The first time there is a "No Show" there will be no charge to the patient, but you will receive a notice from your therapist. Any additional "No Shows" will result in a fee of \$40.00 per appointment. If a patient accumulates 3 "No Shows" we will notify your primary care provider and you may be dismissed from our services. **Extenuating circumstances will be taken into consideration.**

BILLING AGENT CONTACT INFORMATION

Our practice uses a professional billing service to process your claims to healthcare payers and to arrange payment of patient balances. We have all the required agreements in place to insure that your protected health information is safe and remains confidential. If you have inquiries about your healthcare claims, monthly statements, or if you have additional billing information, you may reach our billing agent at: Diversified Health Care Management System (DHCM) - (907) 770-2380.

FINANCIAL AGREEMENT & DELINQUENT ACCOUNTS

Healthcare insurance payers have deductibles, co-payments, limits and other restriction on insurance coverage for Occupational Therapy. It is the patients' responsibility to understanding these restrictions prior to beginning services at Ability Occupational Therapy Services, LLC and to keep these limits in mind when creating a treatment plan with us. By signing this agreement you understand that you are responsible for any and all charges not paid for by healthcare insurance payers (Medicaid, Private Health Insurance Carriers, etc.). By signing this patient agreement, you are acknowledging that you understand this condition of service and commit to promptly paying Ability Occupational Therapy Services, LLC for the services we provide. We accept cash, personal checks, and money orders. We also are willing to make reasonable payment arrangements to keep your account current. Please contact our Billing Office at (907) 770-2380.

RECORD HOLDING & PURGE POLICY

Ability Occupational Therapy Services, LLC will keep hold of the patient file in the inactive files and abides by HIPAA regulations and The Alaska State Law recommended guidelines for holding of health care records for seven years or up to at least the patient's chronological age of 25 years old, whichever is later.

Ability Occupational Therapy Services, LLC highly recommends that you/parent/guardian maintain a folder/binder of assessments, evaluations, re-evaluations, plans of care and home programming sheets for your records.

PERMISSION TO PHOTOGRAPH AND OR VIDEOTAPE RECORDINGS

I allow photographs and or videotaped movies of the patient to be used for documentation of progress and or for parent/guardian home program and training purposes. _____ *Initial and date.*

Ability Occupational Therapy Services, LLC will request a disclosure from the parent / guardian if the photograph(s) and or videotape(s) of the patient will be used for publication and or for trainings of other professionals. _____ *Initial and date.*

PHONES, TEXTING, AND ELECTRONIC DEVICES

Ability Occupational Therapy Services, LLC request that the use of electronic devices be powered to silent or to off during the treatment session, and only be used in cases of emergencies.

PATIENT STATEMENT OF AGREEMENT

My signature below signifies that I have read and understand this patient agreement for Ability Occupational Therapy Services, LLC to provide me Ability Occupational Therapy Services, and LLC. I agree to the terms in this patient agreement and intend to comply with them to the best of my ability. I understand that if I fail to follow the terms of this agreement, I could be discharged from service. I have been provided with these documents that indicate that Ability Occupational Therapy Services, LLC, complies with HIPAA standards: 1) Release of Patient Information, 2) Provider Notice of Privacy practices, 3) Revocation of Authorization for Release of Information.

____ I have read and understand the policy describing parent / guardian participation in treatment. (Please initial).

Signature of Patient OR Personal Representative:	Date:
Printed Name of Personal Representative OR Witness Description of Personal Representative's Authority:	