Speech-Language Pathology Services, LLC | 1012 Marquez Place, Suite 211 Santa Fe, NM 87505 | 505.302.0095 | RiseTherapyNM@gmail.com

Consent for Services

☐ I authorize Rise SLP Services, LLC to render appropriate evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time by Rise SLP Services, LLC in writing. In addition, Rise SLP Services, LLC may terminate services by notifying me in writing.

☐ I do not give my consent or am withdrawing my consent regarding Rise SLP Services, LLC rendering evaluation and therapy services to the client named below.

_____ _____

Print Name of Client Date

_____ _____

Signature of Client or Legal Representative Relationship to Client

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Acknowledgement That You Have Received Our HIPAA Privacy Notice

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 HIPPA, 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.

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:

- 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.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of April 14, 2003 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 policies and procedures of our office. We will not retaliate against you for filling a complaint.

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Please contact the U.S. Department of Health & Human Services Office of Civil Rights at:

200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Rise is required by law to keep your health information and records safe. This information may include:

- Notes from your doctor, teacher or other healthcare provider
- Medical history
- Test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information maybe used and shared.

☐ I acknowledge that I have received a copy of Rise's HIPPA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.

☐ I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.

☐ I understand Rise cannot disclose my health information other than as specified in the notice.

☐ I understand that Rise reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.

_____ _____
Print Name of Client Date

_____ _____
Signature of Patient or Legal Representative Relationship to Client

Please Note: It is your right to refuse to sign this Acknowledgement.

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Attendance / Cancellation / No-Show Policy

Attendance and participation in therapy along with complete compliance with any associated home programs, are essential for therapeutic success.
While Rise understands that illnesses and emergencies occur, we respectfully request that you avoid frequent cancellations or "no-shows". Please adhere to our following policy regarding providing our office with advance notification for any cancellations resulting from a conflicting appointment, vacation, or any other event:

- All cancellations must be submitted at least 4 hours prior to your scheduled appointment in the case of illness and/or emergency. 24 hours is preferred.
- A fee of $40.00 may be assessed if the following occurs. This fee will be billed directly to the client and not their health insurance company, as medical insurance does not provide coverage for missed sessions.
    - If cancellations are made less than the required 4 hours.
    - If the client fails to show up for a scheduled appointment.
- If you miss / reschedule / are more than 10 minutes late for 3 scheduled appointments in a 6-month period, the office reserves the right to discharge the client. Additionally, if you arrive late for a scheduled appointment, the session will still end at the scheduled time or may be cancelled.

I, _____, (client/caregiver name) understand the attendance/cancellation/no-show policy and the risks of not adhering to it.

_____ _____
Print Name of Client Date

_____ _____
Signature of Participant or Legal Representative Relationship to Client

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Payment Policy

Thank you for choosing our private practice to serve you. We are committed to providing you with the highest quality care. Please know that the timely payment of your bill is an integral part of our service and as such, this payment policy is an agreement between you and Rise for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family member. As a client of Rise, you are required to carefully review and sign our payment policy.

Please read the following information carefully:

☐ If utilizing insurance, payment will be billed to insurance at the time of service.
Insurance Provider: _____
Insurance Number: _____

☐ Copays will be collected at the time of service via check or credit/debit card saved on file.
Credit card number: _____
Expiration date: _____
CVV:_____ Billing zip code: _____
Email for receipts: _____

☐ If direct pay, payment is due at the time of service via check or a credit/debit card saved on file.
Credit card number: _____
Expiration date: _____
CVV:_____ Billing zip code: _____
Email for receipts: _____

Checks should be made payable to Rise SLP Services, LLC.

At your request, we will provide you with an invoice outlining the services rendered and the amount charged. You may submit this to your out of network insurance carrier.

Please read and check of all boxes to acknowledge understanding and the sign below:

☐ I give Rise permission to bill my insurance carrier for any and all services rendered (if applicable). I give Rise permission to bill me for my copay (of applicable).

☐ I understand that I am responsible for all costs / fees that any third-party payer (ex. insurance company, private school, etc.) does not cover. In the event that a third-party payer source determines that rendered therapy services are “not covered” or otherwise denied, I will be responsible for all outstanding charges. I understand that I will be billed accordingly and will be responsible for immediate payment. I also understand that Rise will not become involved in disputes between you and your third-party source regarding uncovered charges or reasons for denial.

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☐ I understand that if fees are not paid in full, treatment sessions may be postponed or cancelled until payment is received.

☐ I understand that all returned checks will be subject to a $40 returned check fee. Charges incurred and not paid after 90 days may be turned over to a collection agency at the client's expense. Overdue accounts may also be reported to a Credit Bureau.

☐ I understand that I am responsible for all legal and collection fees, which Rise may incur if payment is not made in accordance with the terms and conditions herein.

☐ I understand that refunds will be issued only in instances of overpayment. All refunds will be processed within 30 days after the overpayment is discovered on the client's bill or at the time the refund is requested. Refunds for payments made with a credit card will be credited back to the credit card used, all other refunds will be issued by a check. Clients who used a third-party source will not be issued a refund until full payment is received from the appropriate source.

☐ I understand that all cancellations require a 24-hour notice, with 4 hours' notice in the case of illness or emergency. There will be a $40 charge for any cancellations made less than 4 hours. This charge is my sole responsibility and will not be covered by a third-party source.

☐ I understand the payment policy and the risks of not adhering to it.

_____ _____

Print Name of Client Date

_____ _____

Signature of Client, Guardian or Responsible Party Relationship to Client

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General Acknowledgement of Forms

☐ I hereby acknowledge and agree that I read all of the forms and documents provided to me in connection with the evaluation and treatment provided by Rise and/or their staff.

☐ I fully understand the meaning and intent of the forms provided and I agree to all content included.

☐ I have been given an opportunity to ask questions about the forms provided. All my questions have been answered to my satisfaction by Rise staff.

_____ _____

Print Name of Client Date

_____ _____

Signature of Participant or Legal Representative Relationship to Client

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Standard Notice: "Right to Receive a Good Faith Estimate of Expected Charges" Under the No Surprises Act

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

• You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
• Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
• If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
• Make sure to save a copy or picture of your Good Faith Estimate.

Good Faith Estimate: For families paying out of pocket at the time of service, Rise Speech-Language Pathology Services, LLC currently charges the following rates:

Full Evaluation: $260
Speech-Only Evaluation: $165
30-Minute Treatment Session: $75 ($65 if paid at the time of service)
45-Minute Treatment Session: $90

Note: Our speech-language pathologists are unable to determine total length of treatment due to variables including type and severity of disorder, co-occurring conditions, attendance, participation, family support, etc.
For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call Rise at (505) 302-0095.

☐ I have read and understand the information provided in this notice.

Parent/Guardian/Client Signature: _____ Date: _____

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Rise Office Policies

Please keep for your reference

The following policies are for the safety and wellness of all the individuals we serve and the therapists that work here.

- **Safety**: The safety of Rise's clinicians and clients is of utmost importance. Any behavior that jeopardizes the safety of our clinicians, clients, and/or client families will not be tolerated and will be grounds for immediate discharge. Please report any unsafe behavior to the clinician.
- **Payment**: It is your responsibility to notify Rise immediately of changes to your insurance and/or you credit card on file. If insurance does not cover services due to a change, you may be responsible for the out-of-pocket expenses.
- **Schedule**: A special block of time is reserved every week for you and/or your child. If you miss / reschedule / are more than 10 minutes late for 3 scheduled appointments in a 6-month period, the office reserves the right to discharge the client. Please communicate directly with your clinician. Please be mindful of this time by adhering to the following:
    - Cancellation: cancellations require a 24-hour notice. In cases of illness and/or emergency, 4 hours' notice is acceptable. There will be a $40 charge for any cancellations made with less than 4 hours' notice. This charge is your sole responsibility and will not be covered by a third-party source.
    - Late-show: If you happen to arrive late for a scheduled appointment, the session will still end at the scheduled time. If you arrive after the 10-minute grace period, your session may be cancelled, and you will be charged. When possible, please notify your clinician if you are running late.
    - No-show: If a therapy session is missed and not cancelled, this is considered a 'no-show'. The client will be immediately discharged after the third no-show and charges may be incurred.
- **Wait room**: This office is a multidisciplinary clinic. Thank you for being courteous while in the waiting room by observing personal space boundaries, safety, and appropriate sound levels.
- **Parking**: Vehicles parked or encroaching within a fire lane or a handicap parking space without a handicap permit shall be towed from the property at the vehicle owner's expense. Notice to the offending driver is not required.
  If you are waiting in a vehicle *with the engine running*, please park away from the buildings along the front or rear walls to avoid fumes that may impact the residents and tenants. If anyone is found to be sitting in their car with the engine running and they are parked near the buildings, any owner/tenant is free to approach the person and instruct them to move their car.
- **Inclement weather**: Rise typically follows the Santa Fe Public Schools weather policy. In the case of weather issues, please communicate directly with your clinician as the session may need to be postponed and/or cancelled due to travel hazards.

We thank you for allowing us to serve your family!