A Better Tomorrow Therapy & Wellness Center, LLC

Demographics & Billing Permissions

Name:_____ Date of Birth:_____

Relationship to Patient:
☐Self ☐ Birth Parent ☐ Adopted Parent ☐ Foster Parent ☐ Legal Guardian

Home Phone #:_____
Email:_____
Appointment Reminders: ☐Text ☐ Email

Cell Phone #:_____
Address: _____
City, State, Zip: _____

Do we have permission to leave a voicemail when trying to contact you? ☐ Yes ☐ No

Emergency Contact:

Name:_____ Contact Number:_____
Name:_____ Contact Number:_____

Providing your email address above and signing below grants ABTAK permission to utilize email communications

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Insurance Information

Primary Insurance: _____
Subscriber's Name: _____
Subscriber DOB: _____
Subscriber SSN: _____
Subscriber ID: _____
Group ID: _____
Address: _____
City, State, ZIP: _____
Phone #: _____

Secondary Insurance: _____
Subscriber's Name: _____
Subscriber DOB: _____
Subscriber SSN: _____
Subscriber ID: _____
Group ID: _____
Address: _____
City, State, ZIP: _____
Phone #: _____

Diagnosis:_____

ICD-10 Code(s) (If Known):_____

Prior Services:_____

Current Services:_____

Additional Information:_____

_____

Signature:_____ Date:_____

A Better Tomorrow Therapy & Wellness Center, LLC

Policies and Authorizations

The following policies and authorizations are mandatory prior to being seen for services at ABTAK. We want everyone to have a clear understanding of our policies.

Please read and initial each policy:

_____ I authorize payment of medical benefits from my listed insurance carrier directly to A Better Tomorrow Therapy & Wellness Center, LLC.

_____ I authorize A Better Tomorrow Therapy & Wellness Center, LLC to provide necessary services to my child.

_____ I agree to notify A Better Tomorrow Therapy & Wellness Center, LLC immediately if there is a change in my insurance carrier. Failure to notify in a timely manner may result in charges being my responsibility.

_____ I agree to pay my portion of the insurance deductible, co-pay, and/or co-insurance directly to A Better Tomorrow Therapy & Wellness Center, LLC within 30 days of a billed invoice.

_____ I understand that tardiness impacts my child's services. If you are more than 10 minutes late to a session it is at the therapist's discretion whether to conduct the session. More than 2 episodes of tardiness in a month could result in removal from your regular scheduled time.

_____ I agree to pay a $10.00 late fee if arriving more than 10 minutes past a scheduled appointment start or ending time.

**Late fees are payable same day and no later than the next scheduled appointment. **This fee is not covered by insurance.

_____ I agree to pay a $25.00 no call/no show fee for appointments that are missed without calling prior to the appointment start time.

** Cancellation after the scheduled appointment start time is considered a no show and fees will apply.

** The no call/no show fee is payable at the next scheduled appointment and no later than 30 days.

** This fee is not covered by insurance.

_____ I understand that 2 no shows within a quarter will result in removal from the schedule.

_____ Consistent attendance is important for your child's progress. It is expected that you have greater than 80% attendance rate or have discussed attendance with your therapist. Attendance rates under 80% could result in removal from the schedule.

_____ I understand that is it my responsibility to initiate discussion with owners if I am having trouble paying my bill or meeting attendance requirements.

_____ I understand failure to make timely payments will result in removal from the schedule and can result in being sent to collections for lack of payment.

_____ I agree to provide a copy of my driver's license number and my social security number (SSN) below. Alternatively, I can pay for services as they are rendered instead of a 30-day grace period from the date invoiced.

Signature of Guarantor:_____ Date:_____

Printed Name:_____ Driver's License #:_____

Relationship to Client:_____ SSN of Guarantor:_____

Thank you for choosing A Better Tomorrow Therapy & Wellness Center, LLC. We understand that you have a choice of providers for your child, and we appreciate your trust in us. Please provide us with feedback on how we can continually improve to best meet your needs.

Thank you!

Krystal and Andrew Vermeire and Jamie and Gerald Bleakley

A Better Tomorrow Therapy & Wellness Center, LLC Ownership Team

A Better Tomorrow Therapy & Wellness Center, LLC

Release of Information Form (ROI)

At A Better Tomorrow Therapy & Wellness Center, LLC your privacy and the confidentiality of your health information are of the utmost importance. To guarantee these things, we at ABTAK, require parental permission to release information to anyone other than another parent / legal guardian.

I,_____ authorize the release of written or verbal information pertaining to my medical program to and from the therapist(s) of A Better Tomorrow Therapy & Wellness Center, LLC and the individual(s) and agencies:

School District:_____

Physician's Office:_____

Therapist(s) or Clinic:_____

Care Giver(s):_____

Other:_____

Other:_____

Signature:_____ Date:_____

This authorization granted by this ROI will be effective for one (1) calendar year from the date of this form.

Your confidentiality and the privacy of your health care information are important to us. Thank you for your support to make this a reality.

Sincerely,

A Better Tomorrow Therapy & Wellness Center, LLC

A Better Tomorrow Therapy & Wellness Center, LLC

Background Information

Do you have allergies? If yes, please explain.

_____

_____

Do you take any medications? If yes, please list what, when, how much, and how often.

_____

_____

_____

What are your main concerns?

_____

_____

What are your goals for seeking therapy services?

_____

_____

_____

Have you received services before? _____ If yes, where? _____

What was your reason for leaving or adding our services? _____

_____

_____

Have you ever had surgery, been hospitalized, and/or had a known traumatic experience that may impact therapy? _____ If yes, please explain.

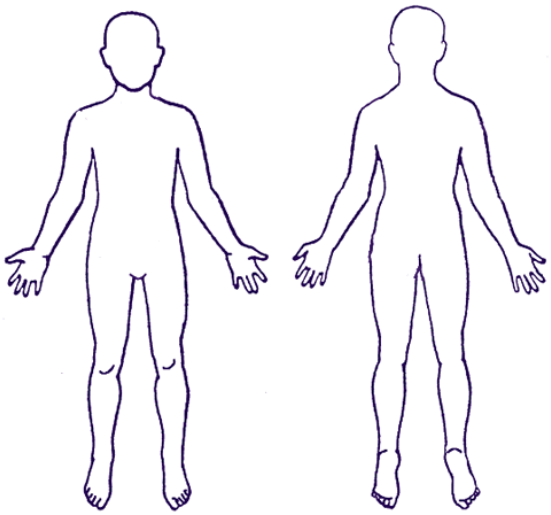
_____

_____

_____

Please mark any areas of pain or concern.

FRONT **BACK**



Rate level of Pain (0-10): _____

Describe injury below:

_____

_____

_____

_____

_____

_____

A Better Tomorrow Therapy & Wellness Center, LLC

HIPAA Patient Information Form

For Your Protection	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.
	We understand that information we collect about you and your health is personal. Keeping your health care information private is one
The Privacy of Your Health Records	of our most important responsibilities. We are committed to protecting your health care information and following all laws about its use. You have the right to discuss with the privacy officer your concerns about how your health care information is shared. The law says: 1. We must keep your health care information from others who do not need it. 2. You may ask us not to share certain health care information. Sometimes, we may not be able to agree to your request (a court order would be an example of one of these situations). The agreement you sign with us may cover health care services you had before now or may have later.
Who will see your protected information?	We review your health care information and submit claims to payers you have agreements with to make sure that you get quality care and that all laws about providing and paying for your health care are being followed. We may also use your information to remind you about appointments or to tell you about treatment alternatives. We may share your health care information with health plans, insurance companies, and government programs to help you get your benefits and so that we can be paid for your health care services.
Your Access to Protected Health Records	In almost all cases, you may see your health care information. You may ask in writing to receive a copy of your health care information. If you think some of your health care information is wrong, you may ask in writing that we correct or add to it. You may ask that the corrected or new information be sent to others who have received your health care information from us. Note: If you are younger than 18 years old and, by law, you are able to give consent for your own health care, then your health care information is kept private from others unless you sign an authorization form.
Others we may share your information with	We follow the law which tells us when we **ARE REQUIRED** to share health care information, even if you do not sign an authorization form. We may be required to report: 1. contagious diseases, birth defects and cancer. 2. firearm injuries and other trauma events. 3. reactions to problems with medicines or defective medical equipment. 4. to the police when required by law. 5. when the court orders us to. 6. to the government to review how our programs are working. 7. to an insurance company who needs to know if received services from us. 8. to Workers Compensation for work related injuries. 9. birth, death and immunization information. 10. to the federal government during the course of an investigation. 11. abuse, neglect and domestic violence, if related to child protection or vulnerable adults. We may also share health care information for government permitted research purposes, for matters concerning organ donations and for serious threats to public health or safety.
Your Right to this Notice	This notice is yours. You may ask for a copy at any time. If there are important changes to this notice, you will get a new one within 60 days if you are currently receiving services. If you have any questions regarding the notice or wish to receive additional information about our privacy practices, please contact our
Questions & Complaints	office. If you believe your privacy rights have been violated, you may file a complaint at our service location(s) either in person or by mail. You may also contact the Department of Health & Social Services Privacy Official by calling 907-465-2150, or by writing to State of Alaska, DHSS Privacy Official, PO Box 110650, Juneau, AK 99811-0650, or by e-mailing the state DHSS Privacy Official at: PrivacyOfficial@health.state.ak.us. You can also contact the federal government Secretary of Health and Human Services (HHS) or to the HHS Office of Civil Rights. **Your health care services will not be affected by any complaint made**.

Signature:_____ Date:_____

A Better Tomorrow Therapy & Wellness Center, LLC

Emergency Medical Release

In the event that medical attention becomes necessary for you while on A Better Tomorrow Therapy & Wellness Center, LLC (ABTAK)

premises, we need your authorization to implement treatment. Please read and sign the statement below:

I, _____, give my permission for ABTAK to contact emergency personnel, on my behalf, in the event of an emergency.

Signature:_____ Date:_____

Media Consent

Dear Student and Parents/Guardians,

We may be recording (audio, video, and digital stills) therapist & client activities associated with A Better Tomorrow Therapy & Wellness Center, LLC. These recordings may be used for educational and informational use in a variety of media. These recordings will **not** be shared, given, or sold for any purposes. All the recorded material is the property of A Better Tomorrow Therapy & Wellness Center, LLC.

Please read the following guidelines and check the one(s) you agree to, then sign and complete the information below:

- ☐ I give permission for any tape recording, video recording, and photography of myself to be used for ***educational*** purposes.
- ☐ I give permission for any tape recording, video recording, and photography of myself to be used ***promotional*** purposes.

Signature:_____ Date:_____

A Better Tomorrow Therapy & Wellness Center, LLC

Informed Consent for Tele-Health Services

I understand that Tele-Health is used when it is not advisable or available for me to visit A Better Tomorrow Therapy & Wellness Center, LLC in person. Reasons to use Tele-Health may include but are not limited to cases of emergency, illness, quarantine, transportation issues associated with remote locations, travel restrictions, illness, or a residential move until local services are made available.

I understand that the rules of confidentiality in Tele-Health are the same as the rules of confidentiality stated in the ABTAK HIPAA Patient Information Form I have read and signed prior.

I understand that the laws protecting the privacy of my child's medical information also apply in Tele-Health.

I understand that the HIPAA Patient Information form I previously read and signed also apply in Tele-Health.

I understand that the information used for evaluation, therapy, follow-up and/or education, may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

I understand that no electronic media is perfect and on occasion, breaches of privacy may occur with Tele-Health.

I understand that because A Better Tomorrow Therapy & Wellness Center, LLC. is licensed by and located in the State of Alaska, that Alaskan laws apply to the standards of care and to the handling of my child's medical records.

I understand that it is my responsibility to help make my Tele-Health therapy sessions successful.

I agree to the best of my ability to arrange a safe, quiet, private place with lighting and internet connection in which to participate in my Tel-Health appointment.

I agree to have my telephone near me (and charged if a cell phone) during my child's sessions as a backup should there be a disruption in video service due to technical difficulties.

Patient Consent to the Use of Telemedicine

I, _____, give my permission for A Better Tomorrow Therapy & Wellness Center, LLCto use Tele-Health as a means of providing for my therapy needs.

I have read and understand the information provided above regarding tele-health. I hereby give my informed consent for the use of Tele-Health in my medical care. I understand that if Tele-Health proves unsuitable for my therapy needs, I can decline future Tele-Health visits without jeopardizing my future access to direct in-office visits with ABTAK.

Signature:_____ Date:_____