Consumer Consent

CLIENT/Responsible Party Acknowledgment
AUTHORIZATION TO CONSENT TO TREATMENT It is understood that this authorization is given to provide authority and power on the part of All Care Therapies & Staffing (ACTS) and SLPTELE, LLC. to give specific consent to any and all treatment which the Speech-Language Pathologist in the exercise of his best judgment may deem advisable.

I consent to ACTS and SLPTELE, LLC. to perform treatment and care via Telespeech as prescribed by a physician and/or recommended by a licensed Speech-Language Pathologist.
I have been advised of all the potential risks, consequences and benefits of telespeech. I have had the opportunity to ask questions about the information presented on this form. I have the right to stop or refuse treatment. I acknowledge and agree that a parent or legal guardian must be present during each treatment session (if client is under 18 years of age).
I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss it with a representative from ACTS and/or SLPTELE, LLC.

CANCELLATION POLICY: To maintain appointment times available for all of our clients, there is a charge of $15.00, BILLED TO CLIENT, for each instance a client does not show for a scheduled appointment and does not give at least 24-hour cancellation notice. After 3 consecutive No Shows, I understand that I may be discharged from services.
HIPAA: I authorize All Care Therapies & Staffing to have access to my medical information.
Notice of Privacy Practice: Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Under HIPAA, providers of healthcare are required to give clients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received. Therefore, I, acknowledge that All Care Therapies has provided a written copy of its Notice of Privacy Practices for Protected Health Information to client or responsible party.
Release Of Records: Any release of medical records information must have a consent signed by the client. When requesting information from another facility, doctor’s office, insurance company, or a release of records directly to the client, a Client Access of Medical Records Authorization is to be completed. The purpose of confidentiality is to protect the client’s rights to privacy to prevent civil or criminal prosecution. The information in the medical record is confidential because it is considered a private communication that exists both legally and ethically between the physician and his/her client. This special communication is to be protected from unauthorized disclosure. Therefore, we must, in all ways possible, preserve the confidentiality of the communication. I do hereby affirm that I have read and understood this and agree on the rules set forth. By my signature below, I hereby authorize the release of my medical records to ACTS and SLPTELE, LLC.
Payment Policy PRIMARY INSURANCE We will bill your primary insurance as a courtesy to you. We assume payment of insurance benefits is not forthcoming on charges older than 60 days. Charges outstanding for more than sixty days will be due in full from you regardless of the type of insurance involved. Any remaining balance after your co-pay and your primary coverage has been paid, including items classified as “above usual and customary”, is due from you upon receipt of the explanation of benefits from your primary insurance carrier. You will be responsible for any item not paid in full by your insurance carrier. Prior to beginning treatment, we will verify your insurance benefits. While we will take all reasonable action to provide accurate therapy benefit information for your specific plan, be aware that verification of benefits is not a guarantee of payment from your insurance carrier. Secondary insurance will be your responsibility to file and collect. **MEDICARE:** We will bill Medicare for you. In most cases, Medicare will pay 80% of allowable charges. We will bill your secondary insurance for you, if you have one, or the balance will be billed to you. **SELF PAY:** Please pay the balance in full at the time of service or upon the receipt of a monthly statement or notice. In the event you are unable to pay the balance in full, we are willing to make reasonable payment arrangements. Please be advised that ACTS and

SLPTELE, LLC. is not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of your account with a collection agency or attorney for collection. Cash and checks are accepted for payment on account. WORKERS' COMP: We will bill your Workers' Comp carrier for your charges. Please note that you will remain financially responsible for all of your charges if your carrier denies coverage. LEGAL SUIT—We will accept a legal letter of protection if you meet each of the following criteria: Do not qualify for benefits under any insurance policy (medical or auto), and Are indigent and cannot pay for charges due using cash or credit card, and Are awaiting settlement and subsequent payment of damages from a related legal case, and Return our lien, signed by both you and your attorney. Prior to your settlement, payment on your account will not be required unless your charges remain outstanding for more than 90 days from the date of last treatment. Upon settlement of your legal case, your balance in full is due within 30 days. Please be aware that you will remain financially responsible for services rendered regardless of the payment option selected above. In the event your account becomes delinquent and therefore in default of payment, the client, legal guardian, or admitting parent will be responsible for the principal amount owing, and all reasonable costs associated with the collection of this debt, including, but not limited to, collection service fees, attorney's fees, and all court cost and additional legal expenses associated with the recovery of this debt. We reserve the right to charge interest on balances over 30 days and charge returned check fees as allowed by state law, and charge a no show fee for missed appointments when adequate notice of cancellation is not provided. Thank you for allowing us the opportunity to serve you If you have any questions about the above information or any uncertainty regarding your insurance coverage, please ask for our assistance. Kindly sign and date this document to indicate that you understand and agree to the terms of this payment policy.

Assignment of benefits/authorization to release medical information/consent to treatment: I hereby assign all medical benefits to which I am entitled to ACTS and SLPTELE, LLC. in the event they file insurance on my behalf, I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes, but is not limited to, collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1.5% per month (12% annually) for unpaid balances over 30 days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of ACTS and SLPTELE, LLC. as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment, excepting acts of negligence.

LIMITS OF CONFIDENTIALITY: Federal and State regulations require that strict client confidentiality be maintained at all times, except when there is evidence of potential injury to oneself and/or others; potential injury to you by someone else; or suspected child abuse, spousal abuse and/or elder abuse. In such instances we are required to report to the appropriate authorities, In addition, information will be released when required by law for public health and law enforcement activity. In accordance with these regulations, we will not disclose any information about you or your participation in this program to any person or institution including school personnel and other family members, without your written consent, except as set forth above.

PRIVACY NOTICE: CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by ACTS and SLPTELE, LLC., for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of ACTS and SLPTELE, LLC. I understand that diagnosis or treatment of me by ACTS's and SLPTELE, LLC.'s providers may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. ACTS and SLPTELE, LLC. is not required to agree to the restrictions that I may request.

However, if ACTS and SLPTELE, LLC. agrees to a restriction that I request, the restriction is binding on ACTS and SLPTELE, LLC's and ACTS's and SLPTELE, LLC.'s Providers. I have the right to revoke this consent, in writing, at anytime, except to the extent that ACTS's Providers and SLPTELE, LLC. or ACTS and SLPTELE, LLC. has taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me, I understand I have a right to review ACTS's and SLPTELE, LLC's Notice of Privacy Practices prior to signing this document. ACTS's and SLPTELE, LLC's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the ACTS. The Notice of Privacy Practices for ACTS is also provided in the client waiting room. This Notice of Privacy Practices also describes my rights and ACTS's and SLPTELE, LLC's duties with respect to my protected health information. ACTS and SLPTELE, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing ACTS's and SLPTELE, LLC's website (www.allcaretherapies.com), calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

CLIENTS RIGHTS In accordance with section 70577(k) and 71507(a), Title 22, of the California Administrative Code, ACTS, SLPTELE, LLC and the medical staff has adopted certain client rights. The undersigned acknowledges that he/she has reviewed the copy of the Client's Bill of Rights posted in the waiting room.

Grievances: If you have a formal complaint or grievance please call 1-877- SLP-TELE.