Talk Sense
Occupational and Speech Therapy

Billing & Financial Policy

The following sets forth the general billing and financial policy of Talk Sense, LLC. Please review this information and sign where indicated.

- I understand that it is my responsibility to provide Talk Sense, LLC with current, accurate billing information at the time of check in and to notify Talk Sense, LLC of any changes in this information.

- I understand that it is my responsibility to know my co-pay, co-insurance and/or deductible benefits prior to services being rendered. I understand that my insurance plan benefit booklet and/or a representative from my insurance carrier can assist me in obtaining this information.

- I hereby authorize the payment of medical benefits to Talk Sense, LLC for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.

- I hereby authorize Talk Sense, LLC to release any medical information necessary to complete and process my insurance claims.

- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $30 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, money order, cashier's check, or credit card.

- I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment.

- I further understand that if I have not made payment after the second statement being mailed, that my account will be flagged for Collection Review and sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.

- I understand that the clinic may also take a verbal request to use my listed credit card for payment on my account or they may also use the same listed credit card on my account should my account become delinquent, or to cover an NSF check.

My signature below confirms that I have read these billing policies and understand my financial obligation as it pertains to the practice of Talk Sense, LLC.

_____
Legal Signature

_____
Relationship to Patient

_____
Date

Laura Barnhill, OTR/L **Leslie Rost, MS, CCC-SLP**
11823 Old Glenn Hwy Ste 108 Eagle River, AK 99577
Phone (907) 694-8255 Billing: (907) 563-1777

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- Conducting normal day-to-day healthcare operations

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that this organization reserves the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request in writing restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with such restrictions.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

☐ Yes, I would like a copy of your Notice of Privacy Practices

☐ No, I would not like a copy of your Notice of Privacy Practices

Patient/Guardian's Printed Name: _____ Date: _____

Patient/Guardian's Signature: _____ Date: _____

If signed by anyone other than patient, indicate relationship and reason why patient is unable to sign: _____

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Notice of HIPAA Privacy Practices

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

I. Our Responsibility

The confidentiality of your personal health information is very important to us. Your health information includes records that we create and obtain when we provide you care. It also includes bills, insurance claims or other payment information that we maintain related to your care. This notice describes how we handle your health information and your rights regarding this information. Generally speaking, we are required to maintain the privacy of your health information as required by law; provide you with this notice of our duties and privacy practices regarding the health information about you that we collect and maintain; and follow the terms of our notice currently in effect.

II. Contact Information

After reviewing this notice, if you need further information or want to contact us for any reason regarding the handling of your health information, please direct any communications to our office at 907-561-1565.

III. Uses and Disclosures of Information

Under federal law, we are permitted to use and disclose personal health information without authorization for treatment, payment, and health care operations. Participants in this organized health care arrangement also share health information with each other, as necessary to carry out treatment, payment, or health care operations relating to the organized health care arrangement. We may share the minimum amount of personal health information necessary for business associates performing services on our behalf.

IV. Other Uses and Disclosures

- As required by law
- As required during an investigation by law enforcement agencies
- In response to legal proceedings
- Other covered entities' payment activities
- Other covered entities' healthcare operations activities to the extent permitted under HIPAA
- Other healthcare providers' treatment activities
- Other public health activities
- To prevent a serious threat to public health or safety
- To workers' compensation or similar programs for processing of claims
- Uses and disclosures required by law
- Uses and disclosures required by law for un-emancipated minors
- Uses and disclosures in domestic violence or neglect situations

V. Any Other Use or Disclosure

Before using or disclosing your personal health information for any other purpose not identified above, we will obtain your written authorization. Unless action has already been taken in compliance with the authorization, you have a right to revoke such authorization by submitting your written request to us.

VI. Your Health Information Rights

• Request that we restrict certain uses and disclosures of your health information; we are not, however, required to agree to a requested restriction.

• Request that we communicate with you by alternative means, such as making records available for pick-up, or mailing them to you at an alternative address. We will accommodate reasonable requests for such confidential communications.

• Request to review or to receive a copy of the health information about you that is maintained in our files and the files of our business associates. We reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. If we are unable to satisfy your request, we will tell you in writing the reason for the denial and your right, if any, to request a review of the decision.

• Request that we amend the health information about you that is maintained in our files and the files of our business associates. Your request must explain why you believe our records require amendment. If we are unable to satisfy your request, we will tell you in writing the reason for the denial and tell you how you may contest the decision, including your right to submit a statement disagreeing with the decision. This statement will be added to your records.

• Request a list of our disclosures of your health information. This list, known as an "accounting" of disclosures, will not include certain disclosures, such as those made for treatment, payment, or health care operations. We will provide you the accounting free of charge, however if you request more than one accounting in any 12 month period, we may impose a reasonable, cost-based fee for any subsequent request. Your request should indicate the period of time in which you are interested. We will be unable to provide you an accounting for any disclosures made before.

• Request a paper copy of this notice. In order to exercise any of your rights described above, you must submit a written request to our office. If you have questions about your rights, please speak with our contact person, available by phone or email during normal office hours.

VII. To Request Information or File a Complaint

If you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to our contact person. You may complain to the Secretary of Health and Human Services (HHS) by writing to the Office for Civil Rights, U.S. Department of Health and Human Services. We cannot, and will not, make you waive your right to file a complaint as a condition of receiving care from us, or penalize you for filing a complaint

VIII. Revisions to this Notice

We reserve the right to amend the terms of this notice. If this notice is revised, the amended terms shall apply to all health information that we maintain, including information about you collected or obtained before the effective date of the revised notice. If the revisions reflect a material change to the use and disclosure of your information, your rights regarding such information, our legal duties, or other privacy practices described in the notice, we will promptly distribute the revised notice, post it in the waiting area of our offices, make copies available to our patients and others, and post it on our website.

Privacy Practice Patient Acknowledgement

I acknowledge that I have received a copy of the Notice of Privacy Practices of Talk Sense, LLC. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Relationship to patient if signed by authorized representative: _____