Jones
THERAPY SERVICES

Authorization to Communicate and Receive Patient Information to/from Other Agencies

Patient Name: _____ Date of Birth: _____

I authorize Jones Therapy Services, LLC to share the following information with the individuals/agencies listed below to assist in the coordination of the above mentioned patient's care or payment for their care. It is acknowledged that sharing or discussing certain Protected Health Information (PHI) with the patient's physician is necessary to provide the best possible care for the patient and authorization to disclose PHI related to the patient's evaluation and treatment to patient's physician is hereby given.

Name/Agency:	Type of Information			
_____	All	Scheduling/Appointments	Medical	Billing/Insurance
_____	All	Scheduling/Appointments	Medical	Billing/Insurance
_____	All	Scheduling/Appointments	Medical	Billing/Insurance
_____	All	Scheduling/Appointments	Medical	Billing/Insurance
_____	All	Scheduling/Appointments	Medical	Billing/Insurance

Specific Instructions or Limitations: _____

_____

_____

I understand that if I need to make changes to who is authorized to receive my information, I may request to update this form at any time.

I understand that the information released may be subject to re-disclosure by some recipients and may not longer be protected by federal and state privacy rules related to health information.

Signature of Patient/Parent/Legal Guardian: _____

Date: _____ Relationship to Patient: _____

To revoke this authorization, please send a request with a copy of this form to the address below:
Jones Therapy Services, LLC
508 Autumn Springs Court, Suite 1A
Franklin, TN 37067
615.614.8833

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Patient Financial Responsibility Form

Patient Name: _____ Date of Birth: _____

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office. We are dedicated to providing the best possible care and service to you. We regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Please be aware of the following:

● AS A COURTESY, Jones Therapy Services, LLC will verify your insurance coverage and bill your insurance company on your behalf. However, you are ultimately responsible for knowing your benefits, including co-payment and coinsurance amounts, requirements for referrals, and any benefit exclusions. For any questions regarding your coverage, contact your insurance company.
● Collection of your estimated portion of the session is due at the time services are rendered. This includes but is not limited to deductibles, coinsurance, copays and any other out of pocket cost estimated to be your responsibility. Failure to do so can result in discontinuation of care.
● You are responsible for any amount not covered by your insurer or additional cost beyond our estimate of your responsibility. If your insurance carrier denies any part of our claim or if you elect to continue therapy past your approved period, you will be responsible for your account balance in full.
● You are responsible for any unpaid, uncovered charges in the event that insurance pays inaccurately. This will include any denials of claims and any take backs due to inaccurate approval of payment.
● You are responsible for any amount not covered by your insurer or additional cost beyond our estimate of your responsibility for an annual re-evaluation for any service you are enrolled in or are scheduling.
● You are responsible for contacting your insurance carrier to discuss exclusion and policy benefits. We do our best to communicate up front if a service is expected to be non-covered; however, these details are not always made available to us upon verification of your policy and benefits.
● You are responsible for informing Jones Therapy Services of any insurance changes. Families will be responsible for any unpaid charges due to changes in insurance coverage, if we were not informed of these changes.
● Jones Therapy Services, LLC may discontinue care for any patient due to non-payment.
● Any unpaid patient's balance that is over 30 days delinquent will be subject to a 20% interest fee.
● Any patient's account that cannot be collected by our office will be turned over to a collection agency. If your account is turned over to collections and there are any collection fees, those fees will be passed on to you.
● A $25.00 fee will be charged for all returned checks.

I have read and understand the above policy regarding my financial responsibility to Jones Therapy Services, LLC for providing treatment to the below named patient and I agree to be bound by its terms. I certify that the information provided is, to the best of my knowledge, true and accurate. I give Jones Therapy Services, LLC permission to submit claims to my insurer. I also grant permission to Jones Therapy Services, LLC to submit any documentation requested by my insurer to process a claim. I authorize my insurer to pay any benefits directly to Jones Therapy Services, LLC.

Printed Name of the Insured: _____

Signature of Patient/Parent/Legal Guardian: _____ Date: _____

Notice of Privacy Practices Acknowledgment

Patient Name: _____ Date of Birth: _____

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), and associated federal and state regulations, I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices (NOPP). I note that the NOPP is on display in the office and is also available on your website. I also understand that Jones Therapy Services has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy.

Patients and their representatives acknowledge that Jones Therapy Services respects patient privacy and that patients and staff shall have an expectation of privacy in all therapy sessions. Accordingly, no recordings are allowed in therapy unless informed consent is provided by all parties for a specific session. Patient hereby gives consent for Jones Therapy Services to record certain sessions on an occasional basis solely for the implementation of the Jones Therapy Services training and annual review process. Patient understands such recordings assist in quality assurance and improvement of services provided by Jones Therapy Services staff. Such recordings shall be deleted upon the conclusion of any utilization in the Jones Therapy Services review process.

_____
Print name of Parent or Legal Guardian (if not patient)

_____ _____
Signature of Patient/Parent/Legal Guardian Date

Office Use Only:

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

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Communication Consent Form

Patient Name: _____ Date of Birth: _____

In order to receive evaluations, progress reports, or notes of any kind without returning to the office, I direct Jones Therapy Services to send to my email, as stated below. I take full responsibility for any wayward emails containing my protected health information. I may revoke this consent at any time.

Preferred Email Address: _____

Signature of Patient/Parent/Legal Guardian: _____ Date: _____

Media Release

With your permission, Jones Therapy Services, LLC would use pictures, videos, etc. for marketing (such as, in our clinic, on our website, brochures, fliers, social media, our Facebook, Twitter, You Tube) and for teaching purposes (such as at professional in-services and presentations at the local, state, and national level). You will be contacted before any media is used.

I grant permission for Jones Therapy Services, LLC to use the following for marketing and teaching purposes:

☐ Pictures ☐ Videos ☐ Audio Recordings ☐ First Name ☐ Age ☐ Diagnosis ☐ NONE

I hereby waive any right to inspect or approve the photographs, printed, or electronic matter that may be used in conjunction with them now or in the future. I waive any rights to royalties or compensation arising from or related to the use of the media. I understand that I am free to address any specific questions regarding this release by submitting those questions to Ginger Jones at 615.614.8833 or info@jonestherapyservices.com.

Signature of Patient/Parent/Legal Guardian: _____

Newsletter Email Participation

Jones Therapy Services, LLC emails a newsletter with tips, tools, tutorials, videos, as well as other health-related updates.

Please check a box to indicate whether you would like to participate:

☐ Opt In ☐ Opt Out

Signature of Patient/Parent/Legal Guardian: _____

Email address: _____

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Patient Name: _____ Date of Birth: _____

Attendance Policy

Jones Therapy Services is committed to you and your family. We want all of our patients to meet their goals and make progress. We feel that this depends on a number of factors including consistent attendance in therapy.

Attendance Requirements

- Please make sure to attend all scheduled therapy appointments. Each session is planned in advance by your therapist(s) based on the outcomes of the previous session. Consistent attendance is essential to make progress towards our goals.
- Your session includes time for discussion, preparing and cleaning the treatment room, and documentation of the session.
- If you must miss an appointment, please speak with your clinician or the office as soon as possible and be ready to discuss rescheduling the missed visit.
- If you will be late for a scheduled appointment, please contact your clinician directly. If you are more than 5-10 minutes late, your appointment may need to be rescheduled. Please speak with your clinician to confirm.
- **Routine tardiness is subject to discharge.**
- If you miss **2 appointments without calling in advance (no-show)**, you will be discharged from therapy.
- There is a **$25.00 charge when you no-show** for an appointment. Insurance cannot be billed when services are not provided, so you will be responsible for these charges.
- If your attendance falls below **85%** you will be discharged from therapy.
- Following any discharge, the physician on file and your insurance provider may be notified.

Scheduling

Someone from our office will contact you within 2-3 weeks to schedule treatment if it has been recommended. **If a preauthorization is required from your insurance company, it may take up to 30-45 business days for them to make a decision and we will schedule treatment once we hear from them**. Please feel free to call our office at 615.614.8833 if you have any questions regarding your evaluation, scheduling, or insurance.

I have read and understand the above policies.

Signature of Patient/Parent/Legal Guardian: _____ Date: _____