FINANCIAL AUTHORIZATION & RESPONSIBILITY

I, _____ (patient/parent/guardian) hereby authorize Carolina Therapeutics, PLLC, billing department to bill my insurance company for direct reimbursement of therapy services rendered to the named client: Client Full Name. Unless otherwise noted, benefit payments will be assigned directly to Carolina Therapeutics, PLLC. All copays and payments are due at the time of service. I understand that the named patient or patient's family is responsible to pay all fees accrued for services rendered, regardless of insurance verification or anticipated insurance coverage, if insurance company refuses to pay provider a portion of the fees or in full. I agree to pay all fees within 30 days after bill has been mailed, and I understand that any fees not paid within 30 days may result in a late fee. In the event of a returned or invalid payment, as well as an unpaid balance over 90 days, I agree to pay any and all additional associated banking, legal and/or collection fees I understand that I am advised to fully know and understand my insurance benefits prior to receiving therapy services. I understand that all insurance plans are different, and it is impossible for Carolina Therapeutics, PLLC, to know the specifics of my plan and/or if my plan will reimburse for services received at all times. I agree to notify Carolina Therapeutics, PLLC, if my insurance coverage changes. I understand that I am ultimately responsible for payment of all services received.

Client Signature

I am aware that not all fees are billable to insurance companies such as materials, books, equipment, school conferences, and therapist consultations and will be billed directly to the responsible party or guardian. I understand that I am responsible for payment of these services not billable to my insurance company.

Client Signature

I have read and understand the policies stated above, and I agree to the terms as stated.

Client Signature

PHOTOGRAPHY & VIDEOS

I, _____ (patient/parent/guardian) authorize Carolina Therapeutics, PLLC, to take photographs /videos to be used to be used for the following purposes:

- Track therapy progress
- For supervision purposes
- Display for commercial use (website, brochures, flyers, etc.)

I have read and understand the policies stated above, and I agree to the terms as stated.

Client Signature

Patient Rights & Responsibilities
Code of Ethics Policy

POLICY

Carolina Therapeutics, PLLC, has a policy in place to inform patients and their families of the Patient's Rights, Responsibilities, and Ethical considerations.

PURPOSE

The purpose of this policy is to ensure that the rights, responsibilities, and ethical considerations have been outlined to all patients, their caregivers/guardians/parents, and the treating practitioners.

PATIENT RIGHTS

This facility and staff have adopted the following list of patient rights. This list shall include, but not be limited to the patient's rights.

- Exercise these rights without regard to sex or culture, economic, educational, or religious background, or the source of payment for his/her care.
- Considerate and respectful care including the appropriate assessment and treatment of individual patient needs.
- Knowledge of the name of the treating clinician, their primary care physician or supervising therapist, and the names and professional relationships of other interagency clinicians who will see each individual patient.
- Receive information about the patient's current level of functioning, the patient's course of treatment, progress and current prognosis.
- Receive as much information about any proposed treatment or procedure as the patient/caregiver/guardian may need in order to give informed consent, or to refuse this course of treatment.
- Participate actively in decisions regarding the patient's medical and behavioral care. To the extent permitted by law; this includes the right to refuse treatment.
- Full consideration of privacy concerning his/her medical and/or behavioral care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discretely. The patient has the right to be advised as to the reason for the presence of any individual.
- Confidential treatment of all communications and records pertaining to the patient's care. The patient/guardian/caregiver's written permission shall be obtained before

protected health information can be made available to anyone not directly concerned with patient care.
- Reasonable responses to any reasonable requests made on behalf of the patient by approved signatories.
- Refuse treatment even against the advice of practitioner.
- Reasonable continuity of care and to know in advance the time and location of appointments, as well as the therapist providing the care.
- Be advised if the patient's clinician proposes to engage in or perform in research affecting the patient's care or treatment. The patient has the right to refuse participation in such research projects.
- Examine and receive an explanation of the patient's bill regardless of source of payment.
- Know which agency rules and policies apply to the patient's conduct while a patient.
- Have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

Exceptions to Confidentiality: (According to G.S. 122C 52-56)

Any information, whether recorded or not, relating to an individual served by a facility and received in connection with the performance of any function of the facility is confidential and may not be disclosed except as authorized by G.S. 122C2 and implementing regulations at 10A NCAC 26B.3

- Except as provided in G.S. 132-5 and G.S. 122C-31(h), confidential information acquired in attending or treating a client is not a public record under Chapter 132 of the General Statutes.
- (b) Except as authorized by G.S. 122C-53 through G.S. 122C-56, no individual having access to confidential information may disclose this information, provided, however, a HIPAA covered entity or business associate receiving confidential information that has been disclosed pursuant to G.S. 122C-53 through G.S. 122C-56 may use and disclose such information as permitted or required under 45 Code of Federal Regulations Part 164, Subpart E.
- (c) Except as provided by G.S. 122C-53 through G.S. 122C-56, each client has the right that no confidential information acquired be disclosed by the facility.
- (d) No provision of G.S. 122C-205 and G.S. 122C-53 through G.S. 122C-56 permitting disclosure of confidential information may apply to the records of a client when federal statutes or regulations applicable to that client prohibit the disclosure of this information.
- (e) Except as required or permitted by law, disclosure of confidential information to someone not authorized to receive the information is a Class 3 misdemeanor and is

punishable only by a fine, not to exceed five hundred dollars ($500.00). (1955, c. 887, s. 12; 1963, c. 1166, s. 10; 1965, c. 800, s. 4; 1973, c. 47, s. 2; c. 476, s. 133; c. 673, s. 5; c. 1408, s. 2; 1979, c. 147; 1983, c. 383, s. 10; c. 491; c. 638, s. 22; c. 864, s. 4; 1985, c. 589, s. 2; 1985 (Reg. Sess., 1986), c. 863, s. 11; 1987, c. 749, s. 2; 1993, c. 539, s. 920; 1994, Ex. Sess., c. 24, s. 14(c); 2009-299, s. 5; 2011-314, s. 2(a).)

Patient Responsibilities:

The care a patient receives depends on the patient's course of treatment and designated therapy service. Therefore, in addition to these rights, a patient has certain responsibilities as well. These responsibilities should be presented to the patient in the spirit of mutual trust and respect.

- The patient/caregiver/guardian has the responsibility to provide accurate and complete information concerning his/her present complaints, past medical history, and other matters relating to his/her health including current level of functioning.
- The patient/caregiver/guardian is responsible for making it known whether he/she clearly comprehends the course of his/her medical treatment, and what is expected of him/her.
- The patient/caregiver/guardian is responsible for following the home exercise plan and carryover activities as recommended by the treating practitioner.
- The patient/caregiver/guardian is responsible for keeping appointments and for notifying the agency and/or treating therapist when he/she is unable to do so.
- The patient/caregiver/guardian is responsible for reading and complying with signed forms, i.e., Consent to Treat, Attendance Policy, and all items outlined by the Parent Handbook.
- The patient/caregiver/guardian is responsible for his/her actions should he/she refuse treatment or not follow recommendations as provided by the treating practitioner.
- The patient/caregiver/guardian is responsible for assuring that the financial obligations of the patient's care are fulfilled as promptly as possible.
- The patient is responsible for following facility policies and procedures.

Organizational Ethics:

Carolina Therapeutics, PLLC, operates under a Code of Ethics. The purpose of this Code of Ethics is to ensure that all members of Carolina Therapeutics, PLLC, patients, caregivers, and guardians are committed to conducting their activities in accordance with the highest levels of business ethics, and in compliance with all applicable state and federal laws and regulations. This Code of Ethics includes:

- The patient/caregiver/guardian is responsible for being considerate of the rights of other patients and facility personnel, which includes refraining from use of foul language and abusive, threatening, or disruptive behavior.
- When communicating by phone or text, the patient/caregiver/guardian is responsible for maintaining a polite and professional manner.
- Clinicians are expected to return emails/phone calls/text messages within 72 hours, and patients/caregivers/guardians are expected to understand that berating messages will not be tolerated by our practice and will place the patient at risk for being discharged.

For additional information on how therapy takes place within your home, please see our handout called "Introduction to In-Home Therapy Services"

I have read and understand the policies stated above, and I agree to the terms as stated.
Client Signature

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

(HIPAA Release)

Basic Demographic Information	
Client Full Name:	
Client Address:	
Client DOB	Patient ID:
Parent/Guardian or Spouse:	
Parent/Guardian Address:	
Phone Number:	

I _____ (Patient, Legal Guardian, or Spouse), do hereby authorize the disclosure of information, records or billing of the above-named patient to: Carolina Therapeutics, PLLC, PO Box 38118, Charlotte, North Carolina, 28278, phone: 704-654-8599, fax: 980-938-6088.

- For the specific purpose(s) of: Any purpose deemed appropriate by my treating clinician(s) at Carolina Therapeutics, PLLC, including but not limited to treating or diagnosing any disease or condition, whether mental or physical.
- Specific information to be disclosed: Any and all information which may be requested by my clinicians at Carolina Therapeutics, PLLC, me, my parent, legal guardian, spouse, attorney, or personal representative, including but not limited to, my educational records, enrollment forms, intake documents, disciplinary documents, evaluations, IEP notes, incident reports, medical/health records or insurance claim materials in your possession, custody, and control, and if necessary, to allow all persons or entities stated herein or anyone appointed by them, to examine these records, or any records containing medical records, medical notes, or medical bills which you may possess regarding my education, physical or mental health conditions, healthcare, or treatment.

I understand that this authorization will expire on the following date _____, event or condition: when either I, my parent, legal guardian, or spouse revokes this authorization in writing.

I understand that if I fail to specify an expiration date or condition, this authorization is valid indefinitely. I also understand that I may revoke this authorization at any time. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I have read and understand the policies stated above, and I agree to the terms as stated.
Client Signature

ATTENDANCE POLICY

Consistent therapy attendance is required by Carolina Therapeutics, PLLC, and it is critical for your child or loved one's success. Nevertheless, we realize that both children and adults suffer sudden illnesses and that emergencies occur. With this in mind, our attendance policy allows for two (2) missed visits (without 24-hours notice) to accommodate those situations. Early notification of a cancellation allows us to provide therapy services to other patients waiting to be seen for therapy. It also provides us with a better opportunity to reschedule your loved one to another time during the week to make up for the missed visit. It is expected that cancelled visits be rescheduled in order to comply with your loved one's plan of care and physician's order.

In order to allow us to meet the needs of all the patients we see, we have attendance policies that, if violated, require that the treating therapist remove your child from a permanent spot on their caseload and discharge the patient from further therapy services. These policies are as follows:

- Cancellation of three (3) appointments with less than twenty-four (24) hours notice in a ninety (90) day period for any reason;
- Not showing or being ready for your scheduled appointment time for two (2) appointments in a ninety (90) day period without prior contact to Carolina Therapeutics, PLLC; or
- Cancellation of three (3) appointments for any reason that are not rescheduled (regardless of advance notice) in a ninety (90) day period.

Please call the office and/or the treating clinician as soon as you realize that your loved one will not be able to attend therapy. You may leave a message on our voicemail twenty-four (24) hours a day.

Parent/Guardian Presence

Carolina Therapeutics, PLLC, values the importance of establishing and maintaining therapeutic programs for all the patients for which we provide therapy services. Parent/guardian involvement is key to your loved one's success from therapy services. Demonstration of your participation within your loved one's individualized home-exercise plan is critical for continual progress towards functional outcomes, and your insurance coverage may require documentation of your compliance. Please be aware that non-compliance with the discussed home-exercise plan may limit your loved one's ability to receive services.

I have read and understand the policies stated above, and I agree to the terms as stated.
Client Signature

CONSENT TO TREAT

I, _____ (patient/parent/guardian), knowing that _____ (Client Full Name) has a diagnosis requiring therapeutic treatment, hereby voluntarily consents to such care for the aforementioned patient by Carolina Therapeutics, PLLC, as may be beneficial in the professional judgment of the patient's therapist(s) and primary care physician. I am aware that no guarantee has been made as to the effect of therapeutic intervention treatment with the named patient.

I am aware that gross motor activities are often encouraged during therapy and that swinging, running, climbing, jumping and other gross motor activities can be used to assist with a variety of skills and performance components the therapist may need to address. I consent to the use of gross motor activities and exempt my loved one, therapist(s), clinician(s), and owner(s) of Carolina Therapeutics, PLLC, from any injury resulting from this type of play.

I am aware that other persons not listed on the patient's prescription may be in the same therapy room during treatment, especially if therapy is provided in-home, at a daycare/preschool setting, or within the community setting. Carolina Therapeutics, PLLC, its clinicians, or owners, are not responsible for any accident or injury that occurs during treatment.

The named patient has my permission to participate in a natural environment setting during therapy sessions. I understand that this presumes the presence of a wide variety of other people including but not limited to, other children, siblings, parents, professionals, volunteers, or students. The named patient may participate in therapy in the home, school, and community as discussed by the clinician, patient, and persons involved in the treatment plan in order to maximize carryover of functional skills.

Each therapist will assign various activities for patients to participate in to maximize the carryover of functional skills as part of the patient's Home Exercise Plan (HEP). I have been notified that compliance with the HEP is necessary in continuing therapy services,

and my insurance and other medical professionals may be notified of my participation, or lack thereof, with the HEP.

I agree that any and all legal claims made against Carolina Therapeutics, PLLC, its therapists, and its affiliated companies, are to be decided by binding arbitration pursuant to the rules of the American Arbitration Association utilizing the laws of the State of North Carolina. I agree to pay all costs associated with binding arbitration, in addition to the attorney's fees of Carolina Therapeutics, PLLC, in the event my legal claims are unsuccessful.

I have read and understand the policies stated above, and I agree to the terms as stated.
Client Signature