INVO BEHAVIOR AND THERAPY SERVICES

PATIENT INFORMATION

Name: _____ M F Date: _____

Address: _____

City: _____ State: FL Zip: _____

Phone: _____ Cell/Alternate: _____

E-Mail Address: _____

Date of Birth: ___/___/____ Age: _____

Primary Care Physician: _____

Physician Phone: _____ Diagnosis: _____ Onset: _____

Referring Physician: _____

Referring Physician Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

Insurance Address: _____

Policy Holder: _____ Date of Birth: __/__/__

Policy #: _____ Group #: _____ Phone: _____

Secondary Insurance: _____

Insurance Address: _____

Policy Holder: _____ Date of Birth: __/__/__

Policy #: _____ Group #: _____ Phone: _____

I certify the above information is correct. I authorize the treatment for Early Intervention, Physical, Speech, Occupational Therapy and/or Applied Behavioral Services, and the release of information for claim purposes. I understand the payment for these services will be directed to INVO Healthcare, Suncoast or Progressus Therapy.

_____ _____

Parent/Legal Guardian Signature Date

INFORMATION AND PHOTOGRAPHY RELEASE

CHILD NAME: _____

_____ I. **AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize INVO Healthcare and Progressus/Suncoast Therapy to release and receive medical records information to/from:

_____ Insurance Companies/Physician
_____ School Board County of _____
_____ Early Steps Program
_____ Other

____ II. **PHOTOGRAPHY/VIDEO RELASE FOR MINOR CHILD OR CHILDREN**

I authorize INVO Healthcare to publish photographs of myself and/or the minor child listed below, for use in the INVO Healthcare's print, online, social media and/or video-based marketing materials as well as educational purposes and other Company publications.

I hereby release and hold harmless INVO Healthcare from any reasonable expectation of privacy or confidentiality for myself and for the minor child or children listed above.

I further acknowledge that participation is voluntary and that neither I, the minor child or minor children will receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other Company publications.

_____ _____

Parent/Legal Guardian Signature Date

HIPPA Compliance Notification for Our Patients

To Our Families,

The misuse of protected health information has been identified as a national problem causing some patients inconvenience, aggravation, and costing them money. We want you to know that all of our employees, managers and therapists periodically receive training to assist them in understanding and complying with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with a particular emphasis on the "Privacy Rule." We strive to achieve the highest standards of ethics and integrity in performing services for our patients.

When it is appropriate and necessary, we provide the minimum necessary information. Other entities may have indirect treatment relationships with you (such as the physician reading your reports) and we may need to disclose personal health information for the purpose of treatment or payment. These entities are most often not required to have patient consent.

You may refuse, in writing, the consent to disclose your personal health information. Under the law, we then have the right to refuse to treat you, should you refuse to disclose your personal health information. At any time in the future, you may request to refuse all or part of disclosure to your personal health information. However, you cannot revoke actions that have already been taken which relied on this or a previously signed consent.

It is our policy to determine appropriate uses of personal health information in accordance with the government rules, laws, and regulations. We want to make sure that our office never contributes to the growing problem of improper disclosure of personal health information. We have implemented a program we believe will help us prevent an inappropriate use of personal health information.

We also know that we are not perfect! Because of this fact, our policy is to listen to our patients and employees without any thought of penalty if they feel that an event in any way compromises our policy or integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. If you have any questions please ask to speak with any one of our staff concerning the problem.

_____	_____	_____
Print Patient Name	Signature of Parent/Guardian	Date

Confidentiality Statement

In accordance with Health Insurance Portability & Accountability Act of 1996 (a Federal Law)

It is the office policy of INVO Healthcare to not release confidential and/or unauthorized information. When returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. If you require healthcare information to be released to someone other than yourself, please complete the following:

I authorize INVO Healthcare to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

May we reach you at home?	Yes	No
May we confirm your appointments by answering machine or text?	Yes	No
If you are employed, may we contact you at work?	Yes	No
May we leave a message for you at work?	Yes	No

It is important to keep you other physicians informed about your care.

If needed, may INVO Healthcare release medical records to your other physicians?	Yes	No

Please list names of authorized people:
Parent(s)_____
Or other person_____Relationship_____

Patient Rights and Complaint Process

I understand that I have a right to refuse treatment at any time. I have a right to review my records, diagnosis, and treatment plan. I understand that if I feel that my rights have been violated, it is my right to file a complaint with the State of Florida.

I certify that I have read and understand the above and I accept all specified terms and fees therein, and have received information on patient rights including the process for initiation, review, and resolution of complaints.

_____ _____ _____

Print Patient Name Signature of Parent/Guardian Date

INVO Healthcare

Patient/Family Financial Responsibilities

Thank you for choosing INVO Healthcare to provide therapy services to your child. We are committed to providing your child with the highest quality services. Please review our financial policies outlined below and ask if you have any questions.

Please initial each statement to acknowledge your understanding and acceptance.

_____ **If You HAVE Insurance:**

Our ability to collect payment from your insurance carrier depends on the accuracy of the information you provide to us. Please let us know immediately when there are changes to your insurance coverage or contact information.

While filing insurance claims is a courtesy we offer our patients, all charges are your responsibility from the date services are rendered. Your insurance is a contract between you and your medical insurance provider and we are not a party to that contract. Although we may estimate what your insurance might cover and pay, it is the insurance company that makes the final determination of your eligibility and benefits.

Not all services are a covered benefit in all policies. **As guarantor, it is your responsibility to know your insurance policy, and be familiar with its coverage and payment rules**. **You will be responsible for all charges not covered by your plan, including those charges in excess of the maximum allowed visits granted on the insurance authorization.**

Following your appointment, we will file a claim with your insurance company. After receiving an Explanation of Benefits (EOB) from your provider, we will bill you for any charges not covered by insurance as well as for any balance your insurance company deems your responsibility (co-insurance, unmet deductible). For clinic appointments, applicable co-pays may be collected at time of appointment.

Please be aware that some private insurance companies can take four to six weeks or longer to turn around an Explanation of Benefits (EOB) statement. Please plan ahead since you may accumulate charges for multiple visits during this time, and you will be responsible for all charges not covered by insurance.

_____ **If You Do NOT Have Insurance:**

All charges are your responsibility from the date services are rendered. You will be billed on a monthly basis.

_____ **If You Have an Individualized Family Service Plan (IFSP):**
All families eligible for the Early Steps program (as indicated by an ACTIVE IFSP) are not responsible for payment. Your insurance company will be *billed first* for services provided, and if they do not pay for services, regardless of the reason, Early Steps will be billed as the payer of last resort.

_____ **Cancellation Fee**
Consistency in services is important for successful progress. Please contact us at least 24 hours in advance if you need to cancel or reschedule your appointment. Appointments missed and not previously cancelled may be charged a fee of $25.00 if you are scheduled for one therapy, $30 if you are scheduled for more than one. As a courtesy, we will text you appointment reminders, but should you not receive the reminder, your scheduled appointment is considered confirmed unless you notify our office via phone or text. Please know our text line is not linked to a cell phone so you may text 24 hours per day to cancel if necessary.

_____ **Returned Checks:**
There is a fee of $20.00 on all returned checks not honored by the bank.

_____ **Billing Questions:**
Our parent company, INVO/Progressus Therapy, handles our billing. If you have questions about your bill, please contact INVO/Progressus Therapy at (800) 892-0640.

_____ **Past Due Accounts:**
If your account becomes past due, INVO Healthcare reserves the rights to:

- Report non-payment of co-pays, co-insurance and deductibles to your insurance carrier.
- Report past-due balances to an outside collection agency, at which time you will be responsible for the outstanding charges, and any applicable collection agency and attorney fees.
- Discontinue services due to non-payment.

By signing below, I acknowledge that I have read and understand the financial policies described above, and have had the opportunity to ask questions.

Patient Name:_____

Responsible Party:_____

Signature:_____ **Date:**_____

INVO Healthcare
Contract for Success

We are excited to start this journey with you and your family. Life is busy, and children are involved in many activities throughout their week. Whether karate, dance, violin or therapy - time is precious! Our staff is committed to giving your family the tools required to be an active member of the therapy team. INVO Healthcare reserves the right to dismiss or postpone treatment for a client at their discretion due to lack of participation, inadequate skill set to address a child's needs, the need for additional prioritized treatment or stagnation of progress.

All members of the team will have expectations. When all members of the team collaborate and work together, success is measurable!

INVO Healthcare Staff agree to the following:

1. to provide the highest quality services available and to help your child to achieve positive outcomes
2. to provide a home program and carryover materials as required
3. to maintain a consistent schedule whenever possible and should we have to cancel- will reschedule the appointment at the earliest convenient time for your family

The client and family agree to the following:

1. to make scheduled therapy sessions a priority
2. to make a good faith attempt at excellent attendance with the understanding that absence from 3 of 5 consecutive sessions constitutes the forfeiture of your current therapy spot for another family
3. to reschedule appointments only in the case of an illness or emergency and make every effort to provide 24 hour notice and reschedule for the same calendar week whenever possible
4. to remain in the clinic during the entire PT/OT/ST therapy session (lobby or therapy room)
5. to have a guardian in the home at all times for home based services
6. to transport patient if necessary into the community and remain with the INVO staff
7. to participate in the home program provided by INVO Healthcare staff

Patient Name:_____

Responsible Party:_____