Dear New Patient Family,

Welcome to the Alliance of Therapy Specialists! Enclosed is our New Patient Packet for you to fill out. Inside you will find an introduction to who we are and what we have been doing for the past 25 years, along with the following disclosures and consents to inform you of your rights as a patient. Please review this packet with your therapist during your initial visit to assure all forms have been signed and dated. If you have any questions about the enclosed forms, your Therapist will be happy to review them with you in person, or you can feel free to call the office directly.

- ☐ *Written Notice of Home Care Consumer Rights*
- ☐ *Home Health Care Agency Disclosure Notice*
- ☐ *HIPAA (Health Information Privacy Act) Notice & Acknowledgement*
- ☐ *Electronic Medical Records Consent*
- ☐ *Cancellation Notice Form*
- ☐ *Authorization and Consent to Treat*
- ☐ *Financial Consent Form*
- ☐ *Review of Systems*

These forms **must be signed** on the day of your initial visit. In the event the signatures are not obtained at your initial visit, the therapist will need to return to your home within 24 hours and have them signed, before treatment can continue.

Thank you very much!

Your Team at Alliance of Therapy Specialists

5750 DTC Parkway, Suite 170, Greenwood Village, CO 80111-5483
303-504-9945 (Phone) 303-504-9946 (Fax)
www.allianceoftherapyspecialists.com

ABOUT US……………

Alliance of Therapy Specialists, Inc. has been providing services to patients in the Greater Denver, Colorado Metropolitan area since 1991! Our mission is to provide quality therapy, empowering our clients to become capable, independent & responsible individuals who value therapy as a healing and learning process. We have a dedicated staff of over 40 professionals including Speech-Language Pathologists, Occupational Therapists & Physical Therapists. We accept most private insurances, including: Anthem, Cigna, Great West, United Health Care, Aetna, Tricare, Humana, Denver Health, Medicaid and Medicare.

Though we provide most of our services in the client's home, we also have a facility in Greenwood Village and are excited to have added a Teletherapy Clinic. Providing Speech-Language Pathology, Occupational Therapy & Physical Therapy in the home & other clinical settings (including schools, nursing homes, senior centers, and even day care centers) using our distinctive model allows our therapists the unique opportunity to create treatment plans that incorporate the home environment & family participation. The ability to collaborate with the patient's caregivers/family promotes carryover between sessions & allows for the greatest amount of therapeutic gain for each patient.

The services we provide are strictly therapeutic in nature. We do not provide emergency care under any circumstance. In case of a medical emergency call 911.

In case of a natural emergency (tornado, flood, blizzard, fire, etc.) please assure your and your family's safety and when possible contact your therapist or your therapist will contact you to reschedule an appointment. If you have an urgent concern that needs to be addressed outside of normal business hours, please contact the office, **(303) 504-9945**.

The therapeutic team at the Alliance of Therapy Specialists takes great pride in providing quality services for our patients. With this in mind, we have set up responsibilities for both our therapists and our patients to insure quality of service will not be compromised.

OUR RESPONSIBILITIES:

- Contact patient/family/caregiver to schedule appointments
- Arrive on time for appointments
- Attend (or make-up) all visits
- Contact the patient well in advance if a need arises to reschedule an appointment
- When possible, obtain appropriate authorization for evaluations and treatment
- Keep patient, family, and all necessary providers informed of ongoing treatment
- Work in a professional, ethical manner
- Arrive properly attired

PATIENT, FAMILY AND/OR CAREGIVER RESPONSIBILITES:

- ***Carefully review, complete and sign new patient paperwork***
- Be at scheduled location for appointment on time
- Be in attendance and actively participate in treatment throughout each visit
- Notify therapist with 24 hour notice when unable to keep an appointment
- Notify therapist of change in Service Coordinator, insurance or physician
- ***Provide a safe and non-distracting environment***

Thank you for choosing Alliance Therapy Specialists, Inc! We are excited to begin working with you and your family!

FINANCIAL POLICY

Alliance of Therapy Specialists, Inc. has a responsibility to provide quality healthcare services to all of our patients. In the interest of maintaining a good relationship and continuing the delivery of quality healthcare, it is our hope that you will take responsibility for your financial obligation to our practice. The following are general policies we have established for our patients; which we believe allows the flexibility that some patients need.

- Unless other arrangements have been made in advance, payment is due at the time of service. We accept personal checks and most major credit cards.
- If you require a statement or claim form to send to your insurance company, please notify our billing department.
- Statements are mailed out each month and any balance owed is due by the 1st of the next month.
- Only after exhausting our own internal attempts for payment will we refer a delinquent account to a collection agency. Should this happen, you will be responsible for all costs incurred in collecting the account. You will be required to pay your account in full before scheduling another appointment if your account is referred to an outside agency for collection.
- Verification of benefits and authorizations does not guarantee coverage.
- Private pay rates:
  - 30 Minutes: $60.00
  - 45 Minutes: $88.00
  - 60 Minutes: $110.00

I have read and understand Alliance of Therapy Specialists, Inc. Financial Policy Agreement and I agree to be bound by its terms. I authorize payment of benefits from my insurance be paid directly to Alliance of Therapy Specialists Inc. I authorize Alliance of Therapy Specialists Inc. to release to my insurance company any and all information necessary for the processing of insurance claim(s).

Patient Name (Please print):____

Parent/Guardian/Caregiver Name:____

Patient/Guardian/Caregiver Signature:____

Date:____

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HIPAA ACKNOWLEDGEMENT AND CONSENT

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 Alliance of Therapy Specialists, Inc., 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 insurance or CCB's).
- The day-to-day healthcare operations of practice.

I have been informed and given a copy of and the right to review the 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 the Alliance of Therapy Specialists, Inc. reserves the right to change the terms of this notice from time to time and that I may contact their office at any given time to obtain a current copy of this notice.

I understand that I have the right to request 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 the restriction.

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

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INFORMED CONSENT TO ELECTRONIC MEDICAL RECORDS & ELECTRONIC PROVIDER SIGNATURES

Alliance of Therapy Specialists, Inc. and its employees (Therapists, Clinical Directors & Administrative Staff) utilize WebPT for all of our patient's EMRs (Electronic Medical Records). This overview is intended to inform you of the use of the EMR system, your rights to access to your records, and your providers' future use of digital signatures.

WebPT provides a HIPAA-compliant data center with SSAE 16 Type II certification and Tier III Certification of Documents from the Uptime Institute. Also, the WebPT application has secure user interfaces and logins that feature 256-bit SSL encryption and strict password guidelines. Your patient medical record in WebPT is a digital version of what Alliance of Therapy Specialist, Inc., previously kept in each patient's paper chart, which contains all of the patient's medical history while in treatment with us.

Your Therapist or Provider will compete all documentation including: Initial Evaluations, Daily Treatment Notes, Progress Notes, Re-Certifications, Case Notes, Transition Reports & Discharges using WebPT in your personal EMR and will sign all documents created with a secure digital signature that has been uploaded to WebPT through their secure portal.

Alliance of Therapy Specialists, Inc. provides a secure communication tool as a courtesy to our patients and their parents through WebPT. It is an optional service that each patient has the right to suspend or reinstate at any time.

Privacy and Security

The document portal has a secure connection that uses encryption to keep unauthorized persons from accessing and reading your health information or records. To help us ensure that this connection remains secure, we need to have your current email address and be informed if/when it changes. Keep your portal User ID and Password secure so that only you or someone authorized by you, can gain access to your or your child's private health information. If you think someone has your password, or the security of your account on the Document Portal in WebPT has been compromised, immediately go to the Document Portal site at www.documentportal.webpt.com and change your Password.

Your email address is confidential and protected information. With our best efforts we will protect this information as we do your medical records and other personal information. We will never share this information with any third party without your prior consent.

All access to your electronic medical record (EMR) is password protected. Our staff is provided with individual logins and passwords which they are instructed never to share. Additionally, in compliance with HIPPA guidelines, our EMR automatically logs all users out after a period of inactivity.

Acknowledgement and Consent
By signing below, you confirm that you have read, understand and agree to comply with our procedures and guidelines for using the Patient Portal. You also agree not to hold Alliance of Therapy Specialists, Inc. or any of their staff liable for Network Infractions beyond their control.

By providing us with your personal email, you gain safe secure access to your EMR on the Web PT Document portal that can be sent within 48 hours of your request. If you do not have a personal email or choose not to provide one, you may still request your medical records be mailed to you by contacting our **Medical Records Department** at (303) 504-9945. You may also send your request to us in writing at : **Alliance of Therapy Specialists, Inc., 5750 DTC Parkway, Suite 170, Greenwood Village, CO 80111**

____
Patients Full Name   Patients Date of Birth

____
Patient/Parent/Guardians Signature   Date Signed

____
Confidential Email Address

CANCELLATION / NO-SHOW POLICY

The policies below are designed to; assist therapists in meeting your treatment goals (continuity of care is important to maximize the outcomes of therapy) and; abide by any contract with referring and/or funding agencies regarding the stipulated number of visits per month, and lastly, in consideration of our therapists.

1. Therapists are not required to wait more than 15 minutes for a late appointment. ***Please call your therapist as soon as you know you will be late.*** Due to scheduling constraints, late arrivals may not be seen on that day, and if seen, the session may end earlier than usual length.
2. If you need to cancel your appointment due to an emergency, please call your therapist as soon as possible. If the therapist cannot be reached, please call our office at **303.504.9945** to let us know and we will notify the therapist for you.

Non-emergency cancellations must be made a minimum of 24 hours in advance.

3. If you have three (3) cancellations, you may lose your standing appointment slot and be offered another day/time or placed on a waiting list for treatment.
4. Two (2) "No Shows" will also result in losing your scheduled therapy time and you will be placed back on a waiting list for treatment.

Please feel free to speak with your therapist about any concerns you may have about this policy. We will do everything possible to provide you with a time that is consistently available for both the patient and the therapist. Thank you for your consideration!

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INFORMED CONSENT FOR THERAPY

I hereby request and give consent to the Alliance of Therapy Specialists, Inc. to perform treatment and care as prescribed by a physician or health care provider and/or recommended by a Community Centered Board.

I understand and am informed that, as in the practice of medicine, speech language and feeding therapy, occupational therapy and physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions answered about my condition or treatment options, prior to treatment.

I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss it with the treating therapist.

I consent and authorize Alliance of Therapy Specialists, Inc. to provide treatment under the direction and supervision of a certified speech-language pathologist, licensed occupational therapist and/or licensed physical therapist.

Patient Name (Please print):____

Parent/Guardian/Caregiver Name:____

Patient/Guardian/Caregiver Signature:_______________________________________

Date:____

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AGENCY DISCLOSURE NOTICE

Agency Type: ☐ Home Care Placement ☒ **Home Health Care** ☐ Personal Care or Non-Medical

Each home care agency or home care placement agency is required to provide the consumer information as to the responsibilities of the agency, the home care worker, and the consumer regarding the employment and duties of each. The Agency, **Alliance of Therapy Specialists, Inc**. is the employer of record for all staff providing direct care services **and is responsible for all items listed below**.

Agency	
X	Employment, Supervision and Background Screening of the Home Care Worker/Therapist.
X	Scheduling and Assignment of Duties for the Home Care Worker/Therapist.
X	Hiring, Firing, Liability and Discipline of the Home Care Worker/Therapist.
X	Provision of supplies or materials for use in providing services to the consumer.
X	Training and ensuring qualifications that meet the needs of the consumer and State Licensing.
Agency	Payment of:
X	Wages, Employment, Unemployment and Social Security Taxes for the Home Care Worker/Therapist.
X	General Liability, Worker's Compensation & Bond Insurance for the Home Care Worker/Therapists.

The above information and areas of responsibility have been explained and any questions have been answered in regard to responsibilities held by the consumer, the home care worker and the agency.

Patient Name (Please print):____

Parent/Guardian/Caregiver Name:____

Patient/Guardian/Caregiver Signature:____

Date Care Started:____

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WRITTEN NOTICE OF HOMECARE CONSUMER RIGHTS

As a consumer of home care and services you are entitled to receive notification of the following rights both orally and in writing. **You have the right to exercise the following rights without retribution or retaliation from agency staff:**

1. Receive written information concerning the agency's policies on advance directives, including a description of applicable state law;
2. Receive information about the care and services to be furnished, the disciplines that will furnish care, the frequency of proposed visits in advance and receive information about any changes in the care and services to be furnished;
3. Receive care and services from the agency without discrimination based upon personal, cultural or ethnic preference, disabilities or whether you have formulated an advance directive;
4. Authorize a representative to exercise your rights as a consumer of home care;
5. Be informed of the full name, licensure status, staff position and employer of all persons supplying, staffing or supervising the care and services you receive;
6. Be informed and participate in planning care and services and receive care and services from staff that are properly trained and competent to perform their duties;
7. Refuse treatment within the confines of the law and be informed of the consequences of such action;
8. Participate in experimental research only upon your voluntary written consent;
9. Have you and your property to be treated with respect and be free from neglect, financial exploitation, verbal, physical and psychological abuse including humiliation, intimidation or punishment;
10. Be free from involuntary confinement, and from physical or chemical restraints;
11. Be ensured of the confidentiality of all of your records, communications, and personal information and to be informed of the agency's policies and procedures regarding disclosure of clinical information and records;
12. Express complaints verbally or in writing about services or care that is or is not furnished, or about the lack of respect for your person or property by anyone who is furnishing services on behalf of the agency.

If you believe your rights have been violated you may contact the agency directly at the address below, attention Executive Director. You may also file a complaint with the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment via mail or telephone: 4300 Cherry Creek Drive South, Denver, CO 80246. Phone: 303-692-2910 or 1-800-842-8826.

Patient Name (Please print):____

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