FOCUS THERAPY SERVICES, INC.

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www.focustherapy.org

HIPAA PATIENT CONSENT FORM

I, _____, understand that as part of my child/ward's health care, Focus Therapy Services, Inc. (hereinafter "**FTS**") originates and maintains paper and/or electronic records describing my child/ward's health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my child/ward's care and treatment,
- A means of communication among the many health professionals who contribute to my child/ward's care,
- A source of information for applying my child/ward's diagnosis to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I further understand that **FTS** reserves the right to change their notice and practices in accordance with Section 164.520 and 164.506 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I have been provided with a **Notice of Privacy Policy** that provides a more complete description of information uses and disclosures.

_____ _____

Signature of Guardian Date

BILLING AND FINANCIAL OBLIGATIONS

As a service to its patients, Focus Therapy Services, Inc. (hereinafter "FTS") provides medical billing for services rendered if so chosen by the patient/parent/legal guardian (hereinafter "patient") per authorized signature on the *Patient Registration* form. FTS maintains every effort to, with the best of the knowledge presented to it, ensure that the patient is eligible and authorized for services per the patient's insurance plan. Ultimately, however, it is the responsibility of the patient to ensure that there is no breach in eligibility or authorization. In the event this occurs, the financial responsibility lies with the patient. If the patient's insurance company reimburses the responsible party, the patient is obligated to use those monies towards the patient's bill at FTS In the event of any change in the patient's insurance, FTS must be notified prior to the next appointment. Consequently, if any changes in insurance are not communicated to FTS by the next date of service, the patient will be responsible for any financial charges incurred. Failure to reconcile these charges could result in a cessation of services until such time that the balance is resolved. By signing this form, I, as a patient or parent/legal guardian of a patient, recognize and accept my insurance, billing and financial obligations to FTS.

_____ _____

Signature of Guardian Date