



FOCUS THERAPY SERVICES, INC.



Main Office
3310 Neuse Blvd. Suite A
New Bern, NC 28560
T#(252)672-8676

Billing Address
P.O. Box 12192
New Bern, NC 28561
Fax 252-672-8677
www.focustherapy.org

Bayboro Office
14180 NC Hwy 55
Bayboro, NC 28515
T#(252)745-5500

Patient Name:

DOB:

Insurance Company & Policy:

PATIENT CONSENT

FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(As required by HIPPA)

With my consent, Focus Therapy Services, Inc. may use and disclose protected health information about my child/children to carry out payments and healthcare operations. Please refer to Focus Therapy Services, Inc.'s *Notice of Privacy Policies* for a more complete description of such uses and disclosures.

The *Notice of Privacy Practices* has been made available to me and I have the right to a copy if I so desire. Focus Therapy Services, Inc. reserves the right to revise its Notice of Privacy Policies Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Focus Therapy Services, Inc. Privacy Officer, P. O. Box 12192, New Bern, NC, 28561.

With my consent Focus Therapy Services, Inc. may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care.

With my consent, Focus Therapy Services, Inc. may mail my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements as long as marked Personal and Confidential.

With my consent, Focus Therapy Services, Inc. may fax or e-mail my appointment reminder cards, patient records, and patient statements. I have the right to request that Focus Therapy Services, Inc. restricts how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations. However the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Focus Therapy Services, Inc.'s use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures or reliance upon my prior consent. If I do not sign this consent, Focus Therapy Services, Inc. may decide not to provide treatment to my child.

Signature of Patient, Parent or Legal Guardian

Print Name of Patient, Parent or Legal 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 Patient, Parent or Legal Guardian

Print Name of Patient, Parent or Legal Guardian

Date _____