BELIEVE THERAPIES

18484 Preston Road Suite 102, PMB 156 Dallas, TX 75252

Phone: 936-293-8800 ● Fax: 936-713-3721

NOTICE OF INFORMATION PRACTICES AND PRIVACY STATEMENT

Believe Therapies, LLC and its employees collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

Information about client's financial situations, medical conditions and care that is provided to the company in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to Believe Therapies, LLC, is held in strictest confidence. Believe Therapies LLC does not give out, exchange, barter, rent, sell, lend, or disseminate any information about the clients who apply for or actually receive services that is considered client confidential, is restricted by law, or has been specifically restricted by a signed HIPAA consent form.

Information is only used as is reasonably necessary to process applications or to provide therapy services which may require communication between Believe Therapies, LLC and health care providers, medical products or service providers, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services needed including, but not limited to; or to obtain or purchase any type of devices. Believe Therapies, LLC may send reminders for therapy via text, email or voicemail. Clients' may specifically request that **NO** information be used whatsoever to certain providers, for reminders, etc., but the client or guardian must identify any requested restrictions in writing.

If the client provided information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Believe Therapies, LLC does not collect information about site visitors except for one hit counter on the main index page that simply records the number of visitors and no other data. Believe Therapies, LLC does use some affiliate links that may or may not capture traffic date through our site. To avoid potential data capture that you visited a website, simply do not click on any of our outside affiliate links.

Any pictures, stories, letters, correspondence, or thank you notes sent to Believe Therapies, LLC becomes the exclusive property of Believe Therapies, LLC. Believe Therapies, LLC reserves the right to use non-identifying information about our clients for promotional purposes that directly relates to the company's mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

Client's may specifically request that **NO** information be used whatsoever for promotional purposes, but the client or guardian must identify any requested restrictions in writing. Believe Therapies, LLC respects the right to privacy and assures clients that no identifying information or photos will ever be used without direct written consent.

BELIEVE THERAPIES

CONSENT & ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I understand that as part of the provision of healthcare services. **Believe Therapies LLC** creates and maintains health records and other information describing among other things, my or my child's health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a **Notice of Privacy Practices** that provides a more complete description of the uses and disclosures of certain health information. Prior to signing this consent, I have reviewed the **Notice of Privacy Practices.** I understand that the organization reserves the right to change the **Notice and Practices** prior to implementation and will make me aware of any changes by updating the website and other social media. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting, or arranging for medical review, legal services, and auditing functions, etc.) and the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me or my child for the purposes of treatment, payment, and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original
3. I have had the right to request that the use of my **Protected Health Information** which is used or disclosed for the purposes of treatment, payment, or healthcare operations be restricted. I also understand that the **Practice** and I must agree to terminate any restrictions in writing on the use and disclosure of my **Protected Health Information**, which have been previously agreed upon.
4. I consent for Believe Therapies to communicate my **Protected Health Information** to the following person or persons (eg. Grandparent, aunt, family friend):

Name: ______________________________ Relationship to Client: ____________________

Name: ______________________________ Relationship to Client: ____________________

______________________________ ______________________________ __________

Client Name Printed Signature of Client or Parent/Legal Guardian Date

____ ____________________

Facility Representative Date

BELIEVE THERAPIES

COMPREHENSIVE TREATMENT PLAN AGREEMENT

The following is a description of this clinic's policies regarding the comprehensive treatment plan. Please read and indicate your agreement to abide by these policies by initialing and signing/initialing where indicated. If you have any questions about these policies please ask a representative of this clinic before signing.

Consent to Treat Initials________

I, the Client/Parent or Legal Guardian hereby consent to treatment for therapy services. I further understand that the plan for treatment is recommended by the doctor primarily responsible for my or my child's care. I understand that I may be seen for treatment by a licensed therapist or therapist's assistant and in order to receive maximal benefit from treatment, it is important for treatment to occur each week, on a consistent basis. I have read and agree to abide by the above policies.

Non Discrimination Policy Initials________

The center does not discriminate against any person on the basis of race, color, national origin, disability, age in admission, treatment, participation in its programs, services and activities, or in employment. For further information contact the Front Office Supervisor. Speech, Hearing and Visual assistance communication guides are available at no charge and upon request. For further information contact the Front Office Supervisor or TTY State Relay at 1-800-735-2988.

Office Policy for Families with Child Clients Initials________

I understand that I should demonstrate behavior that shows respect and consideration for others within the clinic. Believe Therapies, LLC understands that infants and toddlers often need to accompany a parent during treatment; all other individuals are asked to please wait in the waiting area during treatment sessions. I also understand that I am responsible for waiting with my child in the waiting room until the treatment session begins and for monitoring my child's play in the waiting room. I understand that the clinic prefers I wait during the session so that I am able to monitor some of my child's treatment when appropriate. I understand that it is the policy of this clinic that a parent or legal guardian must remain in the clinic during treatment sessions.

Acknowledgement of Risk Initials________

I understand that there is some risk inherent in the use of therapeutic equipment at this clinic, and I agree to indemnify and hold the clinic harmless for any and all losses and claims for any injuries occurring to my child or myself from the use of therapeutic equipment. Furthermore, I understand that the clinic is not responsible for personal belongings left unattended during therapy session.

I, to the best of my knowledge, have provided the clinic with an accurate and complete medical history about present complaints, past illnesses, hospitalizations, surgeries, medications, existence of advanced directives and other pertinent data. I will agree to notify the clinic of any changes in my or my child's condition or circumstances.

Coordination of Care Initials________

I give permission to have this clinic contact and discuss my child's/my case with all persons whose names I have provided as professionals working with my child or myself. I also give permission for this clinic to send copies of progress reports to all referral sources whose names I have provided.

Teaching and Education of Students Initials________

Believe Therapies is a teaching facility. Students may be present and working with me or my child upon occasion. I give permission for occupational, physical and speech therapy students to observe my child's therapy. If I object to a student working with me or my child, I will not initial this section.

Consent to Photograph and/or Video Initials________

Believe Therapies will occasionally take pictures or videos of client's in therapy. They may be used for promotional purposes such as the website, social media and brochures, etc. I give permission for photography/videotaping to be taken of myself or my child for educational and/or promotional purposes. If I object to pictures or video being published as previously stated, I will not initial this section.

Scheduling Policy Initials________

In order for therapy interventions to be successful, the client must be committed to follow the treatment plan of care recommended by the doctor and therapist. **Consistent attendance is key to your success in therapy**. Consistent attendance in therapy sessions allows routine practice of skills, as well as faster progress towards therapy goals. When treatment is not consistently attended, progress slows and the possibility of regression increases. Considering these factors, the following policies have been identified in order to encourage client success.

Clients will attend all scheduled therapy treatment sessions (SEE ATTENDANCE & CANCELLATION POLICY). In the event an appointment must be cancelled, a make-up session may occur with a substitute therapist if the client's regular therapist is unavailable. **If a client will arrive late for a scheduled treatment session, contact must be made to the clinic**. The clinic will attempt to accommodate the client, however if too much time has passed, the session will be considered a no show and will need to be made-up on an alternate day and time.

Once a weekly treatment appointment schedule has been determined, the clinic is often unable to accommodate changes for temporary periods of time. When a permanent change in time is needed, the client must give as much advanced notice as possible for the clinic to attempt to accommodate this request. A change in time may necessitate a change in therapist as well.

Notification of vacations or other obligations is requested at least two weeks prior to the expected absence, to facilitate rescheduling appointment(s). Make up sessions for vacation time will be made-up two weeks before or following the vacation time period.

If a therapist is ill or on vacation, the clinic will make every effort to provide a substitute therapist to ensure continuation of services.

For children under 5 years of age, the clinic requires them to be scheduled for therapy appointments before 3:00 pm. An exception will be considered if there is a school aged sibling attending therapy after 3:00 pm.

I have read and agree to abide by the above policies.

______________________________ ______________________________ __________

Client Name Printed Signature of Client or Parent/Legal Guardian Date

____ __________________

Facility Representative Date

BELIEVE THERAPIES

ATTENDANCE AND CANCELLATION POLICY

Believe Therapies is pleased to offer high quality therapy services. Every attempt is made to schedule services in a timely manner and when possible, at your convenience. Regular attendance is important to achieve progress and success in therapy and it is necessary that all appointments be kept whenever possible. Because of the demand for therapy services and to ensure positive outcomes, we must enforce the following attendance policy:

Attendance:
Therapy services will not be effective unless it is consistent and regular. Therefore, regular attendance at all appointments is important. If two appointments within a four week period are missed, due to either cancellation or no show, and not rescheduled, a discharge from therapy services will be scheduled. Discharged patients are no longer able to receive therapy services and the patient's referring physician will be notified.

Cancellation:
All appointments must be cancelled at least 24 hours in advance by calling or emailing the clinic. The following are considered NON EMERGENCY reasons to cancel an appointment: vacations, pre-scheduled doctor or other medical appointments, family events, parties, recreational events, after school activities, lack of baby sitter, car trouble, traffic, holiday weekend, school holidays, day before or after a holiday, schedule conflict, and sibling illness. All cancelled appointments are required to made-up within the week they were originally scheduled. If two appointments within a four week period are missed and not rescheduled, a discharge from therapy services will be scheduled.

Cancellation Due to Illness - Communicable Disease Policy:
It is the policy of the Clinic that in the event a client becomes ill, the Center will utilize the following guidelines for re-admitting clients into treatments as listed below.

Cancel appointment if one or more of these conditions are present:

- Oral temperature of 100 degrees or above
- Vomiting, nausea or severe abdominal pain
- Marked drowsiness or malaise
- Sore throat, acute cold, or persistent cough
- Red, Inflamed, or discharging eyes
- Acute skin rashes or eruptions
- Swollen glands around jaws, ears & neck
- Suspected scabies or impetigo
- Any skin lesion in the weeping stage
- Pediculosis (Head Lice)
- Diarrhea: runny, watery, or bloody
- Other symptoms suggestive of acute illness

Return to Therapy Guidelines

- Fever free for 24 hours
- Symptom free of vomiting, nausea, or severe abdominal pain
- Symptom free of marked drowsiness or malaise
- Symptom free of sore throat, acute cold, or persistent cough
- Treated Pediculosis (head lice)
- Symptom free diarrhea: runny, watery, or bloody
- All health conditions listed above have been treated and resolved

I agree to call and reschedule my/my child's appointment after the illness has been treated and resolved. Upon the therapist's judgment, your child might be referred back to the PCP.

No Show:

All appointments that are missed without 24 hours notification prior to appointment time will be considered a NO SHOW. All No Show appointments are required to be made-up within the week they were originally scheduled. If two appointments within a four week period are missed and not rescheduled, a discharge from therapy services will be scheduled.

Flex Schedule:

If there are more than 4 requests for reschedule within a month's time, the client will be moved to a flex schedule. On the flex schedule, regular session times are not held for the patient and it becomes the patient's responsibility to call weekly to ask for available appointments. The client will still be obligated to comply with the treatment frequency outlined in the treatment plan of care. If two appointments within a four week period are missed, due to either cancellation/no show or refusal to schedule, and not rescheduled, a discharge from therapy services will be scheduled.

Holidays and School Vacations:

Believe Therapies does not follow the school calendar. We are open 12 months a year and close only for the following holidays: New Year's Day, Memorial Day, July 4th, Labor Day, Thanksgiving Day, Christmas Eve Day, and Christmas Day. Unless otherwise explicitly stated, we are open our regular hours on the days immediately before and after these holidays.

Bad Weather Days:

From time to time the clinic may be required to close due to severe weather conditions. Clinic closings due to bad weather will be posted on our website as well as our social media pages: Facebook and Instagram. The clinic will also attempt to call all clients effected by the closure to re-schedule their appointments.

Purposed Schedule:

In the event therapy is recommended, please list days and times you will be available to receive treatment.

- ☐ Monday: ________________________
- ☐ Tuesday: ________________________
- ☐ Wednesday: ________________________
- ☐ Thursday: ________________________
- ☐ Friday: ________________________

My signature below indicates that I have read the above policy and understand and accept the terms and conditions. I understand that in the event I do not comply with my doctor's recommended plan of care, the clinic is obligated to inform my referring physician with an explanation as to why it has not been able to obtain frequency compliance. I accept the consequences if I refuse treatment or if I do not follow or understand the instructions given to me or my child by the health care team member.

Client Name Printed	Signature of Client or Parent/Legal Guardian	Date

Facility Representative	Date

BELIEVE THERAPIES

BILLING POLICY

The following sets forth the general billing policy of **Believe Therapies, LLC**. The billing process can sometimes be complicated. We want our billing services to be as easy as possible so we would like to prepare you for what to expect. Please review this information and sign where indicated.

Billing Process
Prior to the first visit, Believe Therapies will verify eligibility and benefits. **This is a courtesy service** and the information collected is only an estimate and is only as accurate as what the insurance company has on file at the time. I understand that **THE FEE I AM QUOTED IS AN ESTIMATE** based on (1) anticipated visits to be performed and (2) current information provided to the clinic by my insurance carrier. At each visit, Believe Therapies may collect a co-pay, co-insurance or deductible payment, as pre-arranged based upon your individual insurance plan terms. Claims will then be sent to your insurance company. After the insurance company receives the claim, they may contact you for additional information. Your timely response to their questions will assist your insurance company in processing your claims faster. It usually takes the insurance company 30 – 45 days to pay your claim. After we receive payment, Believe Therapies will provide you with a statement showing the insurance payment and any additional amount you may owe. Please keep in mind that your insurance policy is a contract between you and your insurance company. If you did not follow your insurance plan's terms, they may not pay for all or part of your care. We will contact you if your insurance company does not pay your claims in a timely manner. We are pleased to answer your questions or provide any additional information. Please call the billing office at 396-293-8800 and select the appropriate option once prompted.

- I understand that Believe Therapies, LLC. **will collect payment before every scheduled treatment session,** and has the right to refuse services if payment cannot be rendered.
- I understand that **it is my responsibility to provide** Believe Therapies, LLC with **current, accurate billing information** at the time of check in and to notify the clinic of any changes in this information immediately.
- I understand that it is my responsibility to know my specialist co-insurance, which can be different than my primary care co-payment, and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan; Believe Therapies, LLC also has a contractual agreement with my health plan to collect co-insurances, co-pays and deductibles at the time of service. If I do not pay my patient balances, Believe Therapies, LLC is required to report this to the insurance carrier.
- I understand that if I present an **insufficient funds check** (NSF check) for payment on my account that I **will be charged a $35 NSF fee**. I further understand that to rectify my account, I will be required to pay with cash, a money order or cashier's check.
- I understand that I will be billed for any amounts due by me (co-pays, coinsurance amounts, deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with a statement for any balance due after insurance payment. I further understand that if I have not made payment prior to the following statement being mailed, that statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.

- Prior authorizations are often required before any services are rendered. Most insurance companies will not give a retrospective authorization, hence the use of the term "prior authorization." I understand that the clinic will obtain the necessary prior authorizations before rendering treatment. I also understand that prior authorizations from the insurance companies are often required before services are rendered. **If a prior authorization is not obtained because I neglected to notify Believe Therapies of a change of insurance in a timely manner, I understand that I will be billed for any/all uncovered services.** I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.
- I understand that if I notify Believe Therapies of a change in insurance, my services may be temporarily put on hold until the new prior authorization has been obtained.

My signature below confirms that I have read these billing policies and my financial obligation as pertains to the providers of Believe Therapies, LLC.

______________________________	______________
Client Name Printed	Date
______________________________	______________
Client or Insured Signature	Relationship to Client

FOR OFFICE USE:
I, the facility representative, have reviewed the Billing Policy with the client and obtained signature on the Financial Agreement.

______________________________	______________
Facility Representative	Date