EBS Clubhouse
innovative therapy centers

Cancellation, Illness, HIPAA and Insurance Change Policy 2019-2020

Consistency is vital to the therapy process. Your therapist's plan can only be effective when attendance is regular and consistent with the scheduled therapy time. Please review the guidelines below regarding the cancellation and tardiness procedures:

Late Arrival: Please call the clinic to notify you will be running late to your appointment. Failure to notify will result in a No-Show and total session cancellation after 15 minutes. If you *have* notified the clinic and are 15 minutes late, your session end time will remain the same. If there are three late arrivals within a one month period, a meeting will be scheduled to discuss barriers and possible discontinuation of services. *Late fees and late cancellation fees must be paid prior the child's next session at the clinic.*

Vacation: Please inform the Scheduling Department via email of upcoming absences due to vacation with at least two-week notice. Your therapy session appointment times are not guaranteed to remain at the same after two weeks of suspended service for vacation.
Contact email: CH-Scheduling@ebsclubhousecenters.com

Illness: Please call the clinic and email the Scheduling Department as soon as you know that your child may miss your scheduled session due to illness. Please see below for extended Illness Policy.
Contact email: CH-Scheduling@ebsclubhousecenters.com

Doctor Appointments/Other: Routine Dr.'s visits, meetings and other flexible appointments should be scheduled so they do *not conflict* with *the existing therapy appointment.* Therapy is a medical necessity for your child's development, and should be treated as such.

Inconsistent Attendance: In the event that your family becomes unable to attend sessions regularly, we will make every effort to accommodate your family's needs. Excessive illness will be taken into consideration for continuation of therapy.

Initials: _____

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Illness Policy

While attendance is vital, it is also important to protect your child, as well as the health of the therapists and other children. Please understand that a child must be in good health to have a successful and productive therapy session. We require children to be symptom and fever-free for at least 24 hours prior to returning for a session. If a child is on an antibiotic for an illness, the medication must be administered for at least 24 hours before returning to the clinic. Please contact the clinic as soon as you know that your child may miss your scheduled session due to illness.

The following circumstances warrant cancellation (with possible rescheduling) of the therapy session:

- Child is unusually lethargic or irritable
- Presence of yellow or green mucous secretion
- Vomiting/diarrhea
- Fever (within 24 hours of session)
- Seizures
- Open skin sores
- Rash or hives
- Head lice or nits present
- Pink eye
- Explained rash
- Strep throat
- Chickenpox
- Ringworm (must be 24-48 hours on treatment and completely covered if rash is still present)

Initials: _____

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HIPAA Notification Policy

Please review our Notice of Privacy Practices carefully.

The privacy of your health information is important to us. This notice describes how health information about you may be used and disclosed, and how you can get access to this information.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this HIPAA Notification Policy about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described. This policy takes effect (09/01/2003) and will remain so until further notice.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Policy at any time. For more information about our privacy practices or for additional copies, please contact us using the information listed at the end of this Notice.

Uses and Disclosures of Health Information

We may use and disclose health information about your child for treatment, payment, and healthcare operations.

Possible examples of how your personal health information may be utilized is as follows:
Treatment: We may use or disclose your health information to a physician or other healthcare provider who is providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: If we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes, we may disclose your health information to appropriate authorities.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as e-mail and voicemail messages, or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this policy. We will charge you a reasonable cost-based fee for expenses such as copies, and staff time. You may also request access by sending us a letter to the address at the end of this policy. If you request copies, we will charge you $.35 for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years,

but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (email), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions, please contact us.

Danielle Rincon
Director of Therapy
14050 N. Northsight Blvd.
Scottsdale, AZ. 85260
Phone: 602-368-8601
Email: Danielle.Rincon@ebsclubhousecenters.com

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services upon request. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services.

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We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us, The AZ Department of Health Services, or with the U.S. Department of Health and Human Services.

Initials: _____

Notification of Insurance Changes/ Renewal Policy

EBS Clubhouse Therapy Centers must have CURRENT information on file regarding insurance at all times. It is the responsibility of the parent/ guardian to know of any and all changes in your insurance policy. It is also the responsibility of the parent/guardian to notify EBS Clubhouse Therapy Centers of any changes in the insurance policy within 24 hours.

DDD Policy Holders: Insurance verification is based upon information provided to your support coordinator during your initial meetings and at any time of a change. Once therapy begins, it is our responsibility to first attempt to collect from your insurance. If insurance does not over the therapy provided we then bill DDD and accept the contracted rate as full payment. **It is not the responsibility of EBS Clubhouse to learn of changes in your insurance status at any time following the initial authorization process with DDD.** Failing to report changes of insurance to DDD results in our inability to be compensated for the therapy services provided.

Private Insurance Policy Holders: As a courtesy, we will call to verify benefits and will make reasonable effort to collect from your insurance company. Primary responsibility for understanding coverage limits belongs to the parent. There are instances when insurance may deny benefits (deductibles not met, services not covered under the plan, etc.) and you will be responsible for the payment. Any payment that is due from the parent following an insurance denial is due at the time of service.

AHCCCS Policy Holders: We will request authorizations for therapy services and provide necessary documentation to your policy for ongoing treatment as needed. In the event you have changed your plan, the billing specialist must be notified. There are many

AHCCCS plans to choose from and they are all different. We must have the current plan on file.

ANY CHANGES IN INSURANCE POLICY MUST BE REPORTED TO THE BILLING SPECIALISTS

We thank you in advance for your cooperation.

I have *received a copy* and agree to abide by the terms of EBS Clubhouse Therapy Centers (effective August 2019):

- **Cancellation/Late Arrival Policy**
- **Illness Policy**
- **HIPAA Notification Policy**
- **Insurance Changes and Renewal Policy**

I acknowledge that I have received the Notice of Privacy Practices (Notice). The Notice describes, in accordance with the HIPAA Privacy Regulations, how EBS Clubhouse Therapy Centers may use and disclose my child's protected health information to carry out treatment, payment or health care operations and for the other specific purposes that are permitted or required by law. The Notice also describes my rights and EBS Clubhouse Therapy Centers' duties with respect to protected health information about my child.

_____

Child's Name

_____ _____

Signature of Parent or Guardian Date

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Section A: To the Patient – *Please read the following statements carefully*.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out Treatment, Payment activities, and healthcare Operations (TPO).

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

With my permission the office of ***EBS CLUBHOUSE THERAPY CENTERS*** may call my home or other designated location and leave messages on voice mail that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care.

With my permission the office of ***EBS CLUBHOUSE THERAPY CENTERS*** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient invoices and statements.

With my permission, the office of ***EBS CLUBHOUSE THERAPY CENTERS*** may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder and patient invoices and statements.

I have the right to request that ***EBS CLUBHOUSE THERAPY CENTERS*** restrict how it uses or discloses my protected health information to carry out TPO. However, the practice is not required to agree to my restrictions, but if it does, it is bound by this agreement.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Director of Therapy
Email: Danielle.Rincon@ebsclubhousecenters.com

Section B: Parent or Guardian Giving Consent (if Patient is not 18 years of age and their own guardian)

Name: _____Date: _____

Relationship to Patient: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving written notice of your revocation submitted to ***EBS CLUBHOUSE THERAPY CENTERS attn.: Danielle Rincon.*** Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may *decline* to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____Date: _____