Communication Cottage Therapy LLC
5000 Highway 17 Bypass South
Myrtle Beach SC 29588
PHONE: (843) 252-0033
FAX: (843) 582-0259

CONSENT FOR SERVICES FORM

Thank you so much for selecting Communication Cottage Therapy, LLC as your provider. We have a few important documents to complete prior to initiating services. Please carefully review these documents.

I ________________________ authorize Communication Cottage Therapy LLC to render appropriate evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional.

I ________________________ recognize, agree and understand that I have the right to refuse treatment or terminate services at any time by Communication Cottage Therapy LLC in writing.

In addition, I _________________ understand that Communication Cottage Therapy LLC may terminate therapeutic services by notifying me in writing.

____________________________________ ____

Print Name of Client Signature of Legal Guardian/Printed Name of Guardian

____________________________________ ____

Date of Form Completion Relationship to Client

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HIPAA POLICY NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential.

This Act gives you, the patient, significant new rights to understand and control of how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. HIPAA provides penalties for covered entities that misuse personal health information.
As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

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The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information. The right to amend your protected health information.

The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of June 1, 2020 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact the following for more information:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

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ACKNOWLEDGEMENT OF HIPAA POLICY NOTICE:

Communication Cottage Therapy, LLC is required by law to keep your health information and records safe.

This information may include:

- Notes from your doctor, teacher or other healthcare provider
- Medical history
- Evaluation results
- Treatment notes
- Plans of Care
- Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared.

Please write your name in the following statements to acknowledge that you have read and reviewed this form.

I, ___________________, I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.

I, ___________________, I understand Communication Cottage Therapy LLC cannot disclose my health information other than as specified in the notice.

I, ___________________, I understand that Communication Cottage Therapy LLC reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.

______________________________	______________________________
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______________________________	______________________________
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ATTENDANCE/CANCELLATION POLICY

Attendance and participation in therapy along with compliance with any associated home programs, are essential for therapeutic success. We value open communication with our families. While Communication Cottage Therapy, LLC understands that illnesses and emergencies occur, we respectfully request that you **avoid frequent cancellations or "no shows".**

Please adhere to our following policy regarding providing Communication Cottage Therapy with **advance** notification for any cancellations resulting from a conflicting appointment, vacation, obligations for work or family, or any other event.

All cancellations must be submitted (call/text - do not cancel by email) **24 hours or earlier** prior to your scheduled appointment. Please work with your treating therapist to schedule a makeup session if possible for canceled sessions to allow for continuity of care for the client.

I understand that if any of the following occur, Communication Cottage Therapy reserves the right to discharge my child from therapeutic services.

- If cancellations are made less than the required 24 hours (late cancellation) (2-3x during a care plan cycle)
- If the client fails to show up for a scheduled appointment (first time is a warning, second time discharge)
- If you arrive 15 minutes late to a scheduled appointment (2-3x during a care plan cycle).

If you arrive late for a scheduled appointment, the session will still end at the scheduled time or may be canceled due to the therapist filling that spot with a client. If you fail to appear for an appointment (no show) without providing the appropriate advance notification for 2 appointments within the care plan cycle (12 weeks), Communication Cottage Therapy LLC will reserve the right to cancel all pending appointments and to no longer offer services to you as a client.

I, ___________________, understand the attendance / cancellation policy and the risks of not adhering to it.

I, ___________________, understand that if I do not participate in the home education plan that

Communication Cottage Therapy, LLC reserves the right to discharge the client.

______________________________	______________________________
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ACKNOWLEDGEMENT & ASSUMPTION OF RISK

I ______________________, understand that I am being asked to carefully read each of the provisions in this form.

I ______________________, acknowledge and agree to have receive therapy services from Communication Cottage Therapy, LLC and/or an employee or independent contractor employed by Communication Cottage Therapy, LLC.

I ______________________, acknowledge that there are some inherent risks associated with the use of therapy equipment that cannot be eliminated regardless of the care taken to avoid injuries.

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PHOTO + MEDIA RELEASE/CONSENT

______________________________ ______________________________

Print Name of Client Client's Date of Birth

I ______________________, give consent to Communication Cottage Therapy, LLC or any party authorized by Communication Cottage Therapy, LLC to photograph and/or video record the client indicated above in connection with their therapy sessions, for any purpose subject to the therapist's discretion including but not limited to educational publication, for teaching purposes, and demonstration of progression of their skills.

I ______________________, authorize Communication Cottage Therapy, LLC to use pictures of the child listed above for promotional purposes (ex. social media,website)

I ______________________, acknowledge that I will receive no financial compensation for providing consent since my participation with Communication Cottage Therapy, LLC in providing my consent and release is voluntary.

I ______________________ , hereby release Communication Cottage Therapy, LLC, their contractors, their employees and/or any third parties involved in the creation or publication of Communication Cottage Therapy, LLC. Publication from any and all liability that may arise in connection with the expressed and implied use of all photographs and videos outlined in this form.

I ______________________ , reserve the right to revoke this agreement at any time. If I would like to revoke this I will submit my intent to revoke this agreement in writing via email so that Communication Cottage Therapy, LLC can amend this agreement and update records.

I ______________________ , have the legal authority to execute this consent and release.

______________________________ ______________________________

Print Name of Client Signature of Legal Guardian/Printed Name of Guardian

______________________________ ______________________________

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