

HOMETOWN THERAPY SERVICES**PATIENT INFORMATION SHEET**hometownpediatrictherapy@gmail.com1811 E. MAIN STREET, CHARLESTON AR 72933 ☐609 N. 29TH STREET, OZARK AR 72949 ☐208 E. WALNUT STREET, PARIS AR 72855 ☐

Phone: (479) 461-2324 Fax: (479) 662-4766

Patient Name _____ **Birth Date** _____ **Sex** _____**Social Security #** _____ **Address** _____**City** _____ **State** _____ **Zip Code** _____ **Phone** _____**Parent/Guardian** _____ **Address** _____**City** _____ **Zip Code** _____ **Cell Phone** _____**Work Phone** _____ **Child's Doctor** _____**Primary Insurance Company** _____ **Address** _____**City** _____ **State** _____ **Zip Code** _____ **Customer Service Phone** _____**Policy #** _____ **Group Number** _____ **Relationship to Patient** _____**Insured's Name** _____ **Insured's Date of Birth** _____**Insured's Employer** _____ **Employer's Phone** _____**Secondary Insurance Company** _____**Address** _____ **City** _____ **State** _____ **Zip Code** _____**Customer Service Phone** _____ **Policy #** _____**Group Number** _____ **Relationship to Patient** _____**Insured's Name** _____ **Insured's Date of Birth** _____**Insured's Employer** _____ **Employer's Phone** _____**Arkansas Medicaid #** _____ **Diagnosis** _____**SEEKING SERVICES INCLUDING:** ☐ **PHYSICAL THERAPY** ☐ **OCCUPATIONAL THERAPY** ☐ **SPEECH THERAPY****I CONSENT TO RECEIVE EMAILS:** ☐ **YES** ☐ **NO** **Email Address:** _____**I CONSENT TO RECEIVE TEXTS:** ☐ **YES** ☐ **NO** **Phone:** _____**Please provide a copy of insurance card front and back for billing purposes**

I request payment of authorized insurance, prepaid medical plan, or Medicaid benefits be made to HOMETOWN PEDIATRIC THERAPY SERVICES, LLC (HPT), VANMETER THERAPY SERVICES, LLC (VTS), LAYES THERAPY SERVICES, LLC (LTS), &/or SARAH SPEECH SOLUTIONS, LLC (SSS) for any services furnished by staffed therapists. I authorize any holder of medical information about the above listed patient to be released to the insurance company and to the Health Care Finance Administration (HCFA) and its agents any information needed to determine these benefits payable for services. I consent for HPT, VTS, LTS, &/or SSS to release all information from my child's chart, including goals/IFSP/IPP/IEP to Arkansas Medicaid and/or its contractors for audit review purposes. I consent for my child to receive therapy services.

I authorize my child's physician/primary care provider to share information related to my child's health care, referral, and treatment, including information protected under HIPAA, with Hometown Therapy Services (HPT/VTS) for the purpose of coordinating and facilitating therapy services.

Parent Signature _____ **Date** _____

HOMETOWN THERAPY SERVICES

Acknowledgment of Receipt of Privacy Practices

I, _____, have received a copy of
HOMETOWN THERAPY SERVICES privacy practices.

Child's Name: _____

Address: _____

Signature of Parent/Guardian _____

Date of Signature _____

Name of Witness: _____

Signature of Witness _____ **Date** _____

HOMETOWN THERAPY SERVICES ENCOMPASSES:

1. HOMETOWN PEDIATRIC THERAPY SERVICES, LLC (OCCUPATIONAL THERAPY)
2. VANMETER THERAPY SERVICES, LLC (PHYSICAL THERAPY)
3. LAYES THERAPY SERVICES, LLC (SPEECH PATHOLOGY)
4. SARAH SPEECH SOLUTIONS, LLC (SPEECH PATHOLOGY)

HOMETOWN THERAPY SERVICES
NOTICE OF PRIVACY PRACTICES
Effective Date: 01-01-2023

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) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. 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.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include occupational therapy, physical therapy or speech therapy

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your medical plan for your therapy services.

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 include a periodic assessment of our documentation and administrative protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by text or e-mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

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 certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures 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 request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.

The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.

The right to request an amendment to your PROTECTED HEALTH INFORMATION.

The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.

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

HOMETOWN THERAPY SERVICES

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.

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. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

SHERRY CRIPPEN, OFFICE MANAGER
HOMETOWN THERAPY SERVICES
Phone: (479) 461-2324 Fax: (479) 662-4766
hometownpediatrictherapy@gmail.com

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

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