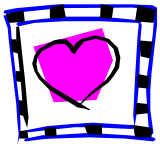


From the Heart Therapy Services

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.

Our pledge to you:

We understand that medical information about you is personal. We are committed to protecting medical information about you. We created a record of the care and services you receive to provide quality care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all the records your care. We are required by law to:

- We are required by law to maintain the privacy of protected health information. We are committed to maintain an oath of confidentiality of your health information.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that are currently in effect.

How we may use and disclose medical information about you:

- **For Treatment:** We may use protected medical information about you to provide you with medical treatment or services. We may disclose protected medical information about you to therapist, therapy students, technicians, or other clinic personnel or are involved in taking care of you. For Example, we will send the Evaluation Report or Plan of Care to the referring physician(s).
- **For Payment:** We may use and disclose protected health information about you to seek payment from your health plan, or to financial institutions when in connection with routine banking activities; such as payment by debit or credit card, or to a third party. For Example, we may need to give your health plan about treatment that you received so your health plan will pay us or reimburse you. We may also tell your health plan about a treatment that you are going to receive to obtain a quote of benefits.
- **For Healthcare Operations:** You healthcare information may be used as necessary to support the day-to-day activities and management of our clinic. For Example, information on the services you received may used to support budgeting and financial reporting, and activities to evaluated and promote quality, or to computer consultants to insure privacy and security.
- **To Business Associates** that we have contracted to perform the agreed upon service. i.e. Billing Service, Accountant.
- **Appointment Reminders:** Your health information will be used by our staff to contact you as a reminder that you an appointment for treatment or medical care or other health-related benefit services.
- We may leave messages on your answering machine or voicemail on the phone numbers that you have provided us regarding appointment times, billing/ insurance/ collections efforts, approval or authorizations.
- **Treatment Alternatives:** We may use and disclose protected health information to tell you about health-related treatments, products, or services that we believe may interest you.
- **Individuals Involved in Your Care or Payment of Care:** We may release protected health information about you to a family member or friend who is involved in you medical care. In addition, we may disclose protected health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, or location.
- **Research**: Under certain circumstances, we may use and disclose health information about you for research purpose, subject to special approval process. We will almost always ask for specific permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care in our practice.
- **Video/ Photograph:** For Evaluations and Re-evaluations the therapist might need to videotape the session. This is required to so that the therapist can review once the evaluation is completed to be able to score the testing. This information is to aid my in my child's treatment planning and evaluation, or to provide feedback and treatment suggestions to my child's clinician or me, and education training to ONLY From the Heart Therapist and Employees.
- **Nannies, Caregivers:** If you arrange for another person (such as a nanny or Caregiver) to transport your child to for from therapy, we might disclose protected health information to them. (i.e. collecting payment for services or relying the results of the therapy session).
- **Emailing:** Occasionally the therapist, staff, and parents might communicate via email regarding appointments, treatment, and/ or other questions that parents might have. If you give us your email address, you are consenting to communicating via email.
- **Auto/Charge:** We offer auto charge for payment of services. We keep on file a patient's credit card number and then automatically charge your card for your payment owed each day that you come in for services. This is only for patient's convenience and their willingness to participate.
- **Serious Threat to Health or Safety:** We may disclose protected health information when necessary to prevent serious threat to your health and safety or to the public's health and safety to someone that can able to help prevent or lessen the threat.
- We may use or disclose health information about you without your prior authorization for several reasons. Subject to certain requirements, we may give our health information about you without prior authorization for **public health purposes, abuse for neglect reporting, health oversight audits or inspections, medical examiners, funeral arrangements, and organ donation, workers' compensation purposes, emergencies, national security and other specialized government functions, and members of the armed forces as required by Military Command Authorities**. We also disclose health information when **required by law**, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders or other **legal process**, such as a court order or subpoena.

Individual Rights:

You have the following rights regarding protected health information we maintained about you:

- **Right to Request Restrictions:** You have the right to request restrictions on our certain uses and disclosures of protected heath information pertaining to treatment, payment or health care operations. We will consider your request and work to accommodate it when possible, but we are not legally required to accept it. All request or appeals must be in writing and submitted to the Privacy Officer listed below.
- **Right to Request Confidential Communications**. You have the right to request that our practice communicate with you about your health and account information in a particular manner or at a certain location. For example to call me at home rather than my work. All requests must be in writing and submitted to the Privacy Officer listed below.
- **Right to Inspect and Copy:** You have the right to inspect and obtain a copy of protected health information but does not include psychotherapy notes, information complied in anticipation of litigation. If you request a copy of health information we may charge a fee for the cost of copying, mailing, or other supplies associated with your request. Texas Law requires that we provide the information within 15 days of your request. We will inform you when records are ready or if we believe access should be limited. If we deny then we will inform you in writing.
- **Right to Amend:** You have the right to amend or submit corrections or missing information to your protected health information by submitting a request in writing that provides reason shy
- **Right to Accounting of Certain Disclosures:** You have the right to request an accounting of any disclosures of your health information we have made except for uses and disclosures for treatment, payment, and healthcare operations. The request must be in writing and only includes dates after April 14, 2003.
- **Right to Cancel:** If you provide us permission to use or disclose health information about you, you may revoke that permission in writing at any time except for disclosures made as a condition of obtaining insurance coverage or for Treatment, Payment or Healthcare Operations for services that have already occurred. If you revoke your permission, you understand that we are unable to take back any disclosures we have already made with your permission.
- You have a **right to obtain a copy** of this notice. You may ask us to give you a copy of this notice at any time.
- **Changes to this Notice:** We reserve the right to change this notice and the revised or changed notice will be effective for information we have about you as well as any information we receive in the future.
- **Complaints:** If you are concerned that your privacy rights may have been violated, you may contact the Privacy Officer listed below. If you are not satisfied with our response you may send a written compliant to the US Department of Health and Human Services which is:

US Dept of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C-5-24-04
Baltimore, MD 21244

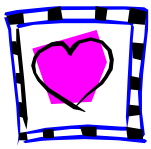
Contact:

If you have any questions or concerns regarding this notice on our health information privacy policies, please contact:

Amy Spargo
From the Heart Therapy Services
PO Box 162904
Austin, Texas 78716
(512) 306-1707

Effective Date

This notice is effective April 14, 2003.



FROM THE HEART THERAPY SERVICES

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been presented a copy of From the Heart Therapy Services Notice of Privacy Practices.

Consent for Usage and Disclosure and Treatment

I hereby give consent to From the Heart Therapy Services and all health care providers and clinic employees furnishing care or service within From the Heart Therapy Services to use and disclose my protected health information for the purpose of treatment, payment and healthcare operations.

I give authorization for From the Heart Therapy Services to send copies of initial evaluations, re-evaluations, status reports and daily progress reports to all referral sources that I have provided:

_____
List the referring doctor(s)

_____
Print Name of Patient

_____ _____
Patient or Patient Representative Date

_____
Relationship to patient

From the Heart Therapy Services

NOTICE OF FINANCIAL POLICIES AND RESPONSIBILITES

We are committed to providing you with the best possible care. If you have medical insurance, we are willing to help you receive your maximum allowable benefits. In order to achieve these goals, we need you assistance and your understanding of our policy.

We will call to obtain a quote of benefits from your insurance coverage. The Quote of Benefits is never a guarantee of reimbursement but an only quote of benefits associated with your insurance health plan. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. We also urge you to call for a quote of benefits or confirm the benefits that are on your policy prior to the evaluation.

You must realize, however that:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
- Our fees are generally considered to fall within the acceptable range by most companies, and therefore should be are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80%) of "U.C.R.". "U.C.R." is defined as usual, customary, and reasonable. However some insurance companies U.C.R could be below our fee.
  This statement does not apply to companies that reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
- Not all services are a covered benefit in all contracts. Some insurance companies and insurance policies arbitrarily select certain services they will not cover. This could include some **codes that the therapist may bill for evaluations and consults**. Or in the event that your health plan determines a service or procedure code to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- Some insurance policies have a calendar or fiscal year limit on therapy. The limit could be a dollar amount that the insurance company will pay out or it could be a number of visits limit. If you exceed the limit on the therapy, you are responsible for the amount in full.
- Some insurance companies require prior authorization or pre-certification. It is your responsibility to make sure that the authorization or pre-certification is in place prior to the evaluation. Also, if the authorization expires or your child exceeds the number of visits, it is your responsibility to obtain a new authorization. If this is not done, then you could be responsible for the therapy sessions in full.

We must emphasize that, as therapy providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients that we are a preferred provider for their insurance, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, Please don't hesitate to ask us. We are here to help you.

Payment is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa and Discover.

If From the Heart Therapy Services is an in-network-preferred provider with your insurance company then we will process your insurance claim-form for your reimbursement and accept assignment of insurance benefits. You are responsible for deductibles, coinsurance, and co-payments at the time of service.

I understand that if From the Heart Therapy is out of network with my insurance company that it is my responsibility to submit to my insurance company the claim to seek reimbursement for the services provided. We will provide you with a Superbill (billing slip) that includes all the necessary information for submission (such as diagnosis, procedure codes, date of service, and this clinic's tax identification number.) We can file the claim(s) as a courtesy; however there is a fee to file those claims if we are not a preferred provider with your insurance company. If you would like this service, please see the front desk to complete the appropriate form.

ASSIGNMENT OF BENEFITS

If we are a preferred provider with your insurance company (in-network), please sign the following:

I hereby authorize and direct my insurance carrier(s) to pay directly to From the Heart Therapy Services all benefits and amounts due for any services rendered. I understand that which has accepted assignment, has the same right as I do to appeal the carrier's determination. I understand that I am responsible for any amount not covered by my insurance health plan.

If we are out of network with your insurance company, you are responsible for submitting to your insurance company the claim to seek reimbursements for services provided.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize From the Heart Therapy clinic to release any information necessary to my insurance carrier(s) regarding the evaluation and/ or treatment for process of an insurance claim.

The terms and consequences of these irrevocable assignments and financial responsibility have been fully explained to me to my understanding; I have signed this document freely and without inducement other than the rendition of services by From the Heart Therapy.

_____ _____

Responsible Party Date

_____

Insured name (if different from above)

_____

Signature of office staff

Cancellation/ No Show Policy

Our office is concerned about time and visit expectations. In an effort improve appointment availability we have found it necessary to enact a Patient Cancellation Policy.

Any patient that cancels an appointment with less than 24 hours notice and/or does not show up for his/her scheduled appointment will be charged a Late Cancellation / Missed Patient Appointment Fee of $25. For the second next Late Cancellation / Missed Patient Appointment the patient will be charged $50. For any subsequent late cancellations or no show appointments the patient will be charged $116.

For EVALUATIONS we require a credit card be on file to charge for any late cancellations or no show fees. Any patient that cancels an evaluation appointment with less than 48 hours notice and/or does not show up for his/her scheduled appointment will be charged a Late Cancellation / Missed Patient Appointment Fee of $50.

This clinic does encourage scheduling a make-up for these and all other sessions in order to ensure optimal progress.

Returned Checks & Outstanding Balances

Returned checks and balances older than 30 days may be subject to additional collections fees and interest charges of 1 ½ % per month. Return checks are subject to a $30 return check charge. After 3 returned checks payment must be one of the following methods: cash, money order, MasterCard, Visa or Discover.

Referral Authorization Policy

It is your responsibility to know in advance if you appointment requires a referral or authorization. If we are in-network with your insurance company and your appointment requires authorization, you will need to have the authorization / referral faxed to us prior to your appointment. If not then your insurance company might not cover the visit and you could be responsible for a higher portion or for the full charge. You are also responsible for contacting the office before your authorization expires or you number of visits have been used, so that we may assist you in getting additional visits authorized or approved. If the authorization expires or you exceed the number of visits, you are responsible for the complete charge of the visit(s).

Copies / Fees for Medical Records

Medical records are furnished to each client on a first time basis free of charge. Then a reasonable fee of $25 for the first twenty pages and $.50 per page for copy thereafter will be charged for copies of medical records. If an affidavit is requested, certifying that the information is true and correct copy of the records, a reasonable fee of up to $15 may be charged for executing the affidavit.

Non Payment Policy:
If there is any outstanding patient balance on your account and no payment has been made toward that balance within 60 days, we reserve the right to put your child's therapy on hold until payment is made.

STANDARD POLICIES

The following is a description of From the Heart Therapy Services policies. Please read and indicate your agreement to abide by these policies by signing where indicated. If you have any questions about these polices, please ask a clinic representative before signing.

ACKNOWLEDGEMENT OF RISK

I acknowledge that there is some risk inherent in the use of therapy equipment at this clinic. I agree to indemnify and hold From the Heart Therapy Services harmless from any and all losses and claims for any injuries or other damage occurring to myself or my child or our belongings from the use of therapeutic equipment.

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

_____ _____
Responsible Party Date

SCHEDULING POLICIES

I understand that a treatment session consists of approximately 53 - 55 minutes of direct treatment. An additional 5 minutes is used for parent consultation, writing treatment notes and treatment planning, and setting up the clinic to tailor the environment to the client's needs for the treatment session. Treatment sessions with adult clients consist of 53-55 minutes of treatment, which includes 5 or more minutes of consultation integrated with treatment.

I understand that, for child clients, additional time needed for a consultation can be provided by scheduling a meeting with the therapist, or by scheduling a phone consultation. A fee for in-depth phone consultation time (more than 5 minutes) for myself or another professional involved in my child's case will be billed at the treatment rate, pro-rated for the amount of time provided. If an insurance company pays for treatment, but does not cover consultation time, this will be billed to me separately.

I understand that once a weekly treatment appointment schedule has been determined, this clinic may be able to accommodate changes for temporary periods of time. When a permanent change in time is needed, I must give as much advance notice as possible for the clinic to attempt to accommodate this request. A change in time may necessitate a change in therapist as well.

I understand that in order to receive maximal benefit from treatment, it is important for treatment to occur each week. I understand that notification of vacations or family obligations is requested at least two weeks prior to the expected absence, to facilitate rescheduling our appointment(s). I understand that we may schedule make-up sessions for vacation time.

I understand that make-up sessions may occur with another therapist from this clinic or my regular therapist.

I understand that when our therapist is ill or on vacation, the clinic will provide the option of another therapist from this clinic to ensure continuation of services. This clinic will make every effort to schedule the therapist at the regularly scheduled appointment time or provide alternative appointment times.

If you are running late for your appointment, please call our office so that your therapist may be notified of the delay. We may or may not be able to extend your time depending upon scheduling.

I understand that services will be terminated when the client has received the maximum benefit from therapy. This will be determined by the From the Heart therapist in conjunction with the client, parent, and physician.

If my account becomes overdue by 60 days from invoice date, I understand that From the Heart Therapy Services will discontinue therapy until payment is made. I understand that my treatment slot will be maintained for two weeks only. A new therapy slot may need to be reassigned upon re-entry to therapy.

COORDINATION OF CARE

When you arrive at the clinic for treatment sign-in at the front desk, make your payment, and then wait for the therapist or therapists' assistants to arrive to escort your child to the treatment area. Patients arriving late for an initial appointment or subsequent appointment(s) or if initial paperwork is not completed, you maybe asked to reschedule the appointment to another day.

In the event that you leave the clinic while your child is in therapy, please return to the clinic 15 minutes prior to the end of his / her appointment. If you have not returned to the clinic by the end of the therapy session, the clinic will be forced to charge $1.00 per minute for your child's care. After the first 10 minutes the charge increases to $5.00 per minute.

I understand that a conference to discuss the results of the evaluation will occur within two weeks after the last date of the evaluation and I will receive a written report of the findings at that time. I understand that this will be a separate visit and a separate charge. Some insurance health plans might not cover this consult. If they consider it a "not covered" service, you will be responsible for the complete charge.

I understand that Re-evaluations progress reports are routinely completed at intervals of 3, 6, 9, or 12 months or more frequently if indicated or requested, based upon your child's initial evaluation. Parent treatment planning conferences may be scheduled at these times to discuss my child's current abilities and continued therapy needs and to plan future treatment goals and objectives. I understand that the report and the meeting each will be billed according to our fee schedule. All other services (such as home, school, daycare, and work-site visits, travel and phone conversation) will be charged at the standard fee per hour for the number of hours utilized. If an outside agency pays for treatment but does not authorize payment of reports or meetings, I understand I will be billed for these separately.

I understand that this clinic is willing to provide additional calls or meetings following the initial consultation, if requested. I understand these additional services will be billed at the standard hourly fee for our clinic.

I understand that I need to provide notification of outside meetings or consultations at least three weeks in advance to allow our therapist to prepare and to coordinate meeting dates and times. I understand that if my therapist is unavailable, this clinic will make every effort to have another therapist attend the meeting.

SCHOOL VISITS

If you would like your child's therapist to make a school visit for an observation or for an ARD or IEP consult, you will be responsible for the visit. This charge will NOT be billable to your insurance company. The charge is $116 per hour.

OBSERVATION CONFIDENTIALITY

I in my observation at From the Therapy Services agree to keep confidential any and all protected health information about the persons observed within the scope of this clinical experience.

I acknowledge that this protected health information is part of From the Heart Therapy Services policy as well as Federal and State Law and any violation could result in criminal or civil prosecution.

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

_____ _____

Responsible Party Date

DIVORCED PARENTS:

In the case of divorced parents or shared custody arrangements, the court specifies the healthcare responsibilities for the child and boundaries of the involved parties. If the patient is a child of divorced parents or shared custody, please answer the following questions based on the court document that specifies the child's healthcare needs.

According to decree, which parent may consent to treatment and coordination of healthcare needs:

☐ Mother ☐ Father ☐ Mother or Father ☐ Both Parents Required

SPECIALIZED VIDEOTAPE & PHOTOGRAPH

I give consent for myself and my child to be videotaped or photographed by therapists / employees of From the Heart Therapy Services for the following reasons.

Evaluation & Treatment Planning
I understand that this videotape / photograph will only be viewed by the evaluating/ treating therapist.

a. To aid my child's or my treatment planning and evaluation.
b. To provide feedback and treatment suggestions to my child's clinician or me.
c. Educational Training to ONLY From the Heart Therapist.

All information obtained in these tapes and photographs will be available to me. I understand that this tape will not be copied or used for any other purpose than stated above. I understand the above authorizations may be rescinded at any time when presented in writing by myself or other authorized guardian to From the Heart Therapy Services.

EMERGENCY CARE WAIVER – RELEASE

I binding my heirs, executors, , administrators, estate, and assigns, do hereby release and agree not to hold liable From the Heart Therapy Services, it's officers, agents, and employees, from any and all actions, causes of action, claims, demands, costs, or damages as a result of property damage or personal injuries sustained by myself, my child/children, or my property, arising from or resulting from any act of omission, or otherwise From the Heart Therapy Services, it's officers, agents, and employees while participating evaluation or treatment while at the clinic.

I further release From the Heart Therapy Services, their officers, agents, and employees, from all liability for personal injury resulting from my child's failure or the failure of other participants in the activity to obey safety regulations and directions of the activity leader in good faith, in response to emergencies contained herein shall excuse any employee of From the Heart or person assigned to be an activity leader by an employee of From the Heart; from the responsibility to activities with reasonable care for my child's safety during the course of the activity appropriate to the circumstances.

I hereby authorize From the Heart Therapy Services consent to arrange emergency medical or dental treatment for my child while my child is a participant in From the Heart Therapy Services treatment, therapy, and therapy program or summer camp. I understand that From the Heart Therapy Services will make all reasonable efforts to contact me and provide me with notice in the event that my child requires emergency medical or dental treatment. In the event that From the Heart Therapy Services cannot contact me and give me notice, I understand that I am hereby authorizing From the Heart Therapy Services to consent to such treatment on my behalf. I understand that From the Heart Therapy Services will seek necessary emergency treatment for my child only in the event my child is injured or harmed while engaged in a program or activity sponsored by From the Heart Therapy Services.

_____
Print Patient's Name

_____ _____
Signature of Parent / Guardian Date

_____
Print Name of Parent / Guardian

_____
Signature of office staff

FROM THE HEART THERAPY SERVICES

COMMUNICATIONS VIA EMAIL

_____	_____
Print Name of Patient	Patient's Date of Birth

☐ I hereby give authorization to From the Heart Therapy Services therapists or staff to disclose / communicate via email regarding my child. I understand that email could use and/ or disclose protected health information. There is always a questionable level of security when dealing with Internet Email; however, we will try to uphold privacy and security via email communications. I also understand that I should not use email to contact the therapist or staff of From the Heart Therapy in case of an emergency.

_____	_____
Print Name of Parent / Guardian	Email address
_____	_____
Print Name of Parent / Guardian	Email address

☐ I do not wish to communicate via email regarding my child.

_____	_____	_____
Patient or Patient Representative Signature	Relationship to Patient	Date