Authorization for Services:

I, ________________________________, authorize Apex Therapy, NC to provide the following

services to ___________________________________:
(child's name)

Patient's Name Gender: M/F	Date of Birth
Parent/Guardian Name(s)	**Address**
Phone Number	**Email**

_______ Screening _______ Consultation _______ Evaluation ______ Treatment

________ Physical Therapy _______Occupational Therapy _______ Speech and Language Pathology

Authorization for Supervision during Therapy Sessions.

The following persons may be present in the absence of the parent/guardian during therapy sessions:

______________________________ ______________________________

I understand and concur that I have the right to decline or cease treatment/services at any point by informing Apex Therapy, NC. Additionally, Apex Therapy, NC may terminate services by informing me of the discontinuation, as well as stating the reason.

All treatment is contingent upon the results of the evaluations and future recommendations of the therapist.

______________________________ ______________
Signature of Parent/Guardian Date

____
Printed Name

Consent to Obtain and Release Information

I, _______________________________, give Apex Therapy, NC my consent to obtain and release information on _______________________ verbally and/or in the form of written evaluations and progress reports to the following person(s) or agencies listed below:

Name of Physician/Carolina Access Primary	Phone
Address	

Insurance Company/Medicaid	Group Name
Group Number	ID Number
Address	Phone Number

Guarantor Info:

Name	Date of Birth

CDSA

Name	Phone
Address	Purpose

____ _______________________

Parent/Guardian Signature Date (This document expires after 1 year)

I understand that I may revoke this authorization at any time by notifying Apex Therapy, NC in writing.

Financial Policy

The following is a statement of our financial policy which we require you to read and sign prior to any treatment.

Medicaid as the primary insurer:

a. Medicaid continues to be the primary insurer. Medicaid card should be shown monthly to the therapist.
b. Carolina Center for Medical Excellence (CCME), who provides approval for the treatments, continues to approve the therapy.
c. Apex Therapy has sufficient staff to provide the treatments needed by the patients.

Private Insurance is the primary, Medicaid is the secondary:

If Medicaid is the patient's secondary insurance, we will bill the primary insurance and one of two things will take place:

a. Within 60 days of treatment, the primary insurance company pays at least what Medicaid would have paid. In this case, there is no additional patient responsibility for the treatments;
b. Within 60 days of treatment, the primary insurance company pays some but less than what Medicaid would have had it been the primary insurer. In this case, Apex Therapy bills Medicaid for the balance due. The patient pays nothing.
c. Within 60 days of treatment, the primary insurance company provides no denial of payment. Since we cannot bill Medicaid without a denial or proof of partial payment, we may have to discontinue therapy.
d. Apex Therapy must be informed of ANY changes of private insurance due to Medicaid billing laws.
e. Apex Therapy must be an approved provider by your insurance company.

Private insurance only:

We file all claims whose payments can be assigned to Apex Therapy. If, within 60 days of treatment, the primary insurance company pays some portion of the bill to Apex Therapy, the responsible party will be billed the balance due. If the insurance company has not provided any payment, the entire bill becomes the responsibility of the responsible party. If the patient pays and the insurance company pays Apex Therapy, later, a credit or refund is issued to the responsible party. Apex Therapy must be informed of ANY insurance changes. Insurance will be verified at time of first visit and your co-payment/coinsurance amounts will be determined at the first visit for all in-network therapies. All co-payments/coinsurance amounts are due at the time treatment is rendered. If your child is seen at the home/daycare, your invoice will be mailed to you. Please make payments promptly upon receipt of claim.

Wake County Early Intervention Contract:

Apex Therapy is a contracted provider with Wake County Early Intervention who will pay a portion of the therapy based on their sliding scale.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

______________________________ Signature of Parent/Guardian

____________ Date

______________________________ Printed Name

RELEASE FOR APPOINTMENT REMINDERS

I, ______________________ (Print), hereby authorize Apex Therapy, NC to send me an appointment reminder via e-mail or text message using the following information.

Email reminders may contain patient or clinic information such as, but not limited to, patient first name and clinic location.

Patient / Guardian Contact Information:
(Please print clearly and legibly)

E-mail: ______________________________

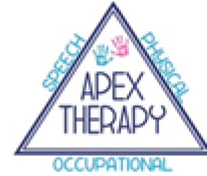
Cell phone: ______________________________

Patient / Guardian (Print): ______________________________

Signature: ______________________________

Date: ______________________________

Note to Office Managers:
Confirm that the E-mail and Cell Phone provided above match the information in the patient information screen.



1031 Pemberton Hill Road, #101
Apex, NC 27502
apextherapync@gmail.com
www.apextherapync.com
Phone: (919) 372-5489 Fax: (866) 889-4751

Apex Therapy NC, Inc.
Patient Attendance Policy

Apex Therapy NC, Inc. and its therapists are dedicated to providing consistent services to help your children achieve their therapeutic goals as quickly as possible. Consistent attendance is necessary to help your child reach these goals. Missed sessions can not only delay your child's progress, but they also prevent us from being able to help other children waiting for services, in addition to placing a financial strain on your therapist, as insurance companies do not reimburse for canceled and no-show sessions.

Therefore, as the parent/legal guardian of the patient of our practice, you agree to the following terms regarding appointment attendance.

Sick Children/Caregivers

We appreciate your help in reducing the spread of germs. Please do not bring sick children/caregivers to our office or have the therapist come to your home or daycare when anyone in the home/daycare is ill. This is to protect the families we serve as well as our therapists, especially those with weakened immune systems. Even a simple cold for one child can manifest as a serious illness requiring hospitalization for another individual. As we work in close proximity with your children, our therapists often catch viruses from the children we serve. We then can infect the other families with whom we work and/or miss work as a result. *Sickness is defined as a fever of 100.3 or greater, runny noses, sneezing, coughing, vomiting, and diarrhea.*

If you or your child are sick, please call our office or email your therapist by 8:30 a.m. the day of your session. If you or your child has a fever, you or your child must be fever-free for 24 hours prior to the session without the use of fever-reducing medicine prior to coming into our office. For home/daycare visits, this applies to any person in the home or daycare.

If you or your child are ill for a scheduled session and notify us after 8:30 a.m. the day of the appointment or do not cancel and arrive ill to our office or when we come to you, we will cancel the session and a $50 missed appointment fee* will be charged. If we come to your home, this also applies to any individual in the home.

Initial here: ____

Initial Evaluation Cancellation

In order to hold your child's evaluation time slot, please be advised that we may ask for a $50 deposit* prior to your appointment. This deposit is to review your records and communicate prior to the evaluation. If you must cancel your appointment, you must do so 72 hours (three days) before the scheduled appointment time to receive your deposit back (minus the time already taken to review your files, records, etc.) If you fail to cancel your appointment within 72 hours or if you miss the appointment, you will forfeit your deposit. Once the evaluation has been completed your deposit will be credited to the patient's account.

Initial here: ____

Session Cancellations

We hold a time slot for your child's sessions. Most families have limited times and days they can schedule their therapy sessions, which are often commonly requested times for other families as well. We do our best to meet your scheduling needs and keep your sessions consistent for you. When you cancel or miss a session with short notice, we are often unable to see another child in that open time slot. Therefore, if you exceed a cancellation rate of 3 or more

missed appointments within 2 months, you will be forfeiting your weekly time slot/s and will need to contact us to schedule your next therapy session. This policy includes emergency, non-emergency, and vacation cancellations.

Non-Emergency cancellations require a minimum of 24 hour notice. Non-emergencies include vacations, pre-planned medical appointments, family events, parties, sports events, lack of babysitter, or anything that is not designated as an "emergency" (see below). The session must be canceled or rescheduled no later than 24 hours before the appointment time. If non-emergency cancellations become excessive (i.e. 3 or more within a two-month period) the patient may lose their weekly slot in the therapist's schedule. If the session is not canceled within 24 hours notice a $50 missed appointment fee* will be billed to the patient’s account. This fee must be paid in order to keep the next scheduled visit. If a make-up session is made when you call to cancel and the make-up session is kept, at the practice's discretion, the fee may be waived.

*Emergency cancellation*s require notification by 8:30 am the morning of your child’s appointment, please call our office or email the child’s therapist. Emergency cancellations are accepted only for illness, illness of a family member or death in the family. These sessions must be canceled by 8:30 am on the day of the appointment, in the absence of notifying us, the session will be considered a no-show and the $50 missed appointment fee* will be charged.

Initial here: ____

No-Shows

A “no show” is a missed session without prior notification as well as a visit cancellation less than one hour before your appointment time. Any “no show” will incur a $50 missed appointment fee*. Two “no shows” in a 2-month period may result in losing your time slot, being moved to our waiting list or termination of therapy services.

Initial here: ____

Treatment Make-Up

We will offer make-up sessions when scheduling allows and as long as the make-up sessions are within the same authorization period as the missed visits. Make-up slots are offered for inclement weather, illness, pre-arranged vacations/holidays, and therapist cancellations. Make-up sessions are not offered when there is a violation of the cancellation policy. For example, if you cancel a session less than 24 hours prior to the session, we will not reschedule that visit. Make-ups must be attempted and kept for all holidays, vacations, and cancellations. Failure to schedule and attend a make-up session will be considered a cancellation and the $50 missed appointment fee* will be charged.

Initial here: ____

Late for Appointments

If you arrive more than 10 minutes late for a session, we will be unable to see your child and will need to reschedule the session. Late arrivals are considered a cancellation and a $50 missed appointment fee* will be charged. Additionally, if arriving more than 10 minutes late consecutively for two (2) or more therapy sessions, your therapy time slot may be forfeited and your child may be moved to the patient waiting list.

Initial here: ____

Extended Absences:

If the patient misses two (2) or more therapy sessions consecutively without advanced notice noted above, the time slot will be in jeopardy and your child may be moved to the patient waiting list. We can hold a patient’s assigned time slot for up to 3 weeks due to extended leave/vacations when 14 days advance notice is given to the treating therapist. If more than 3 sessions in a 2-month period are missed without being rescheduled, the patient will be moved to our waiting list or discharged from services.

Initial here: ____

Inclement Weather:

We follow the National Weather Service advisories in determining inclement weather. Please contact us as soon as possible if you are uncomfortable driving to our clinic due to inclement weather.

Initial here: ____

Dismissal

To ensure continuity of care for your child, if you will be discontinuing services for any reason, you must give our office three weeks' notice. In accordance with NC state law, this office will provide you with 30 days' notice if treatment will be discontinued for breach of the attendance policy.

Initial here: ____

Clinician Cancellations

If your therapist is not able to attend your child's session, you will be contacted as soon as possible. Please be sure that our office knows the best way to reach you. Every effort will be made to reschedule your appointment in a timely manner.

Initial here: ____

Caregiver Attendance Policy

Caregivers are encouraged to attend therapy sessions when it would be therapeutically beneficial for the patient. If a caregiver is not present in a session, **we will reserve the last 5 minutes of each session for consultation with you regarding progress and any changes to the home care plan.** All children must be accompanied by an adult at all times in the waiting room.

For your child's safety, caregivers are required to remain on the premises during your child's therapy sessions. Please inform your therapist or our office staff if you will wait in your vehicle. If you choose to remain in your vehicle, we require that you are within eyesight of our front door so that we can immediately reach you in case of an emergency. **Please plan on meeting your therapist in our waiting room 5 minutes prior to your session ending for end-of-session consultations.**

Initial here: ____

Appointment Reminders

Future therapy sessions should be made and confirmed at the end of each session. As a courtesy, your child's therapist may send an email reminder the day before a scheduled appointment. However, attendance is not dependent upon the receipt of an email reminder.

If you wish to receive email reminders, please list your preferred email address:

____

I have read, understand, and agree to the Patient Attendance policy.

Patient/Legal Guardian Printed name: ______________________________

Patient/Legal Guardian Signature: ____________________________________ **Date**: ________________________

Child's Name(s):______________________________

* Due to NC Medicaid policy, fees will not be applied to accounts of patients receiving Medicaid coverage, however, all other terms of our attendance policy apply.

COVID-19 Consent for the Use of Teletherapy for Early Intervention

Services Child's Name ______________________________

Provider's Name ______________________________

Discipline(s) ______________________________

Agency ______________________________

Parent(s)/Guardian Acknowledgment and Statement of Consent

I agree that my child and family may receive early intervention services via teletherapy. I consent to the following:

1. I have the option to refuse the delivery of any early intervention service (including teletherapy) at any time without risking the loss or withdrawal of any early intervention service to which my child and I would otherwise be entitled.
2. All applicable confidentiality protections, as defined in the "Family Rights: Notice of Family Rights and Procedural Safeguards in the North Carolina Early Intervention" brochure, shall apply to the services.
3. I shall have access to all early intervention information resulting from the sessions conducted via teletherapy as provided by applicable law for parental access to my child's record.

Verbal consent obtained on this date: ______________________________

Parent(s)/Guardian name: ______________________________

EISC notified date: ______________________________

This consent should be retained in the provider's client record.

This consent is valid for twelve months from the date of verbal parental consent.

PATIENT ACKNOWLEDGEMENT

Patient Name: ___________________________________ D.O.B.: _____________

I understand that the patient's health information is private and confidential. I understand that Apex Therapy, NC, works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Apex Therapy, NC, may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations.

Apex Therapy, NC, has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgement. I understand that I have the right to read the "Notice of Privacy Practices". If I ask, Apex Therapy, NC, will provide me with the most current "Notice of Privacy Practices".

Within the "Notice of Privacy Practices" is contained a complete description of the patient's privacy/ confidentiality rights. These rights include, but aren't limited to, access to my child's medical records; restrictions on certain uses; receiving an accounting of disclosures by laws; and requesting communication be by specific methods of communications or alternative locations.

Apex Therapy, NC, has established procedures which help them meet their obligations to patients. Their procedures may include other signature requirements, written acknowledgements information, and non-routine information needs, etc. I will assist Apex Therapy, NC, by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

_______________________________________ _______________

Parent/Guardian Signature Date

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK T. BENTON • Assistant Secretary for Public Health
Division of Public Health

To: All North Carolina Infant-Toddler Program Families, Staff, and Providers

From: Sharon E. Loza, Early Intervention Branch Head

Date: July 30, 2020

RE: COVID-19 (Coronavirus) Updated Guidance

The North Carolina Early Intervention Branch (EIB) is monitoring the COVID-19 pandemic closely. The virus continues to spread in North Carolina and nationwide. A high priority of the NC Infant-Toddler Program (ITP) is to ensure the safety and wellbeing of our families, staff, and providers. To minimize face-to-face contact during this time, we have embedded virtual home visits and tele-services to provide services and to coach caregivers to enhance their children's growth and development.

With the increased cases and hospitalizations, the NC ITP continues to strongly encourage remote and virtual services to our families. We continue to look at all options to support our participants and families in a safe and effective manner.

If families or providers opt for face-to-face services, we urge you to follow the DHHS guidelines to wear a mask, wash your hands frequently, and keep 6 feet of distance. Also, in accordance with Governor Cooper's Executive Order No. 147, face coverings will be required where physical distancing of six feet is not possible. These measures are in place to ensure the safety of our children, families, staff, and providers as well as to limit virus spread among our fellow North Carolinians.

If families opt for face-to-face services, the Infant-Toddler Program provides the following safety guidance:

- No face-to-face services should be provided in the following circumstances:
  - a provider or family/household member has tested positive for COVID-19;
  - a provider or family/household member is showing COVID-19 symptoms (including fever, chills, new cough, shortness of breath, difficulty breathing or new loss of taste/smell);
  - a provider or family/household member recently had close contact with a person diagnosed with COVID-19; or
  - a provider or family/household member has been instructed to quarantine or self-isolate.
- Contact the family to ask about the above circumstances prior to the visit.
- Provider should wear a face covering at all times that physical distancing of six feet is not possible
  - In cases where the child has hearing impairment or needs to see one's mouth, it is recommended that providers consider wearing a transparent or clear face mask or face covering with a clear panel in the front. If available, a transparent face mask may be used to improve visability.

- Face coverings should be worn by adults, or children over the age of 2 if it is determined that the child can reliably wear, remove, and handle masks following CDC guidance (i.e. not frequently touching face covering, etc).
- Face coverings should NOT be placed on:
  - children under 2
  - anyone who has trouble breathing, or is unconscious, incapacitated or otherwise unable to remove the face covering without assistance; or
  - anyone who cannot tolerate a face covering due to developmental, medical, or behavioral health needs.

- Practice physical distancing of 6 feet whenever possible. This also allows for maximizing coaching instruction with the child's caregiver.
- Consider conducting visit in lower risk setting if possible, such as outdoors.
- Provider should practice frequent hand hygiene, washing hands with soap and water for at least 20 seconds or using hand sanitizer with at least 60% alcohol.
- Provider should clean and sanitize any toys or equipment according to CDC guidelines between uses.

If any contracted Service Provider or Provider employee who has either tested positive for COVID-19 or is exhibiting known signs and symptoms of COVID-19 and continues to perform in-person visits, that provider will be in violation of the Provider Agreement clause that states: *Service Providers shall ensure that all health and safety codes are followed, and that infants and toddlers being evaluated for eligibility or enrolled in the N.C. ITP are not at risk of sustaining harm or injury.* As a result, providers may have their Agreement terminated immediately.

If any family or provider or anyone in their home tests positive, believe that you have been exposed, or are showing any signs and symptoms of COVID-19, contact your Local Health Department or health care provider. You can also get more information on symptoms and testing sites or what to do if you are sick.

For additional information, please visit: NC DHHS COVID-19 Webpage; Know Your Ws: Wear, Wait, Wash; and NC DHHS COVID-19 Materials & Resources

We appreciate your support as we navigate these trying times together. The NC ITP will continue to reassess the situation to determine how best the program can provide services and support during this time.

Thank you for your continued support and commitment to infants/toddlers and their families in the North Carolina Infant-Toddler Program.

cc: Mr. Mark Benton
Dr. Kelly Kimple

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability & Accountability act of 1996 (“HIPPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us is 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 how your health information is used. “HIPPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPPAA”, 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.

We may use and disclose your medical records only for each of the following purposes:

- **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 collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Healthcare operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer services. An example would be an internal quality assessment review.

We may also 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:

- 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 friend, or any 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 receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

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.

This notice is effective as of April 14, 2003 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 our privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of the notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information: For more information about HIPPAA or to file a complaint:

The U.S. Dept. of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.,
Washington, D.C. 20201