7011 Gum Branch Road
Richlands, NC 28574
Phone: (910) 430-2201
Fax: (910) 324-4325
Fax: (888) 653-7243
Email: prosteptherapy@gmail.com

Pro Step Therapy Admission Agreement

Patient's Name___________________________________ DOB: _______________________

Consent for Service:
I hereby authorize the staff of Pro Step Therapy to administer therapy services as ordered by my physician and as are included in my plan of care. I acknowledge and agree that Pro Step Therapy is not responsible for damage, theft or similar occurrences within my home during the provision of care by Pro Step Therapy.

Authorization for Payment of Services:
Medicare/Medicaid Patients: I certify that the information given by me in applying for payment under Medicare and Medicaid is correct. I consent that I am not receiving these services from a different provider and request that payment of authorized benefits be made on my behalf to Pro Step Therapy. I will be financially responsible for services rendered not paid by Medicare or Medicaid.

Private Insurance Patients: I certify that the information given by me in applying for payment from my insurer is correct. I request that payment of authorized benefits be made on my behalf to Pro Step Therapy. I will be financially responsible for services rendered that are not paid by my insurance.

Self-Pay Patients: I understand that I will be billed for services and supplies rendered to me by Pro Step. I accept responsibility for payment for services rendered by Pro Step.

I further certify that the staff of Pro Step Therapy has explained to my satisfaction my rights and responsibilities as a patient. I have had my plan of care and goals explained to me and agree with them. I understand my right to confidentiality and received a copy of the "Notice of Privacy Practices."

____ ______________________
Patient's Signature Date

____ ______________________
Witness Date

The undersigned party agrees to be responsible for and pay any obligations of the above patient's obligations owed to Pro Step. (Patient is unable to sign.)

____ ______________________
Guardians Signature Date

7011 Gum Branch Road
Richlands, NC 28574
Phone: (910) 430-2201
Fax: (910) 324-4325
Fax: (888) 653-7243
Email: prosteptherapy@gmail.com

Pro Step Therapy
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFROMATION. PLEASE REVIEW IT CAREFULLY.

This notice is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This notice describes how we may use and disclose your/your child's protected health information (PHI) to carry out treatment, payment, and healthcare operations and for other purposes that are permitted or required by law. PHI includes any of your/your child's written or oral health information including demographic data that can be used to identify you/your child. This is PHI that is created or received by Pro Step Therapy and/or its agent.

Understanding Your/Your Child's Health Information

Each time you/your child receives health related services a record is made of the treatment. Typically, this record contains the diagnosis and treatment notes. This information, often referred to as a health, treatment or medical record, serves as a

- Basis for planning your/your child's care
- Means of communicating among the health professionals (physician) who contribute to your/your child's care
- Legal document describing the care you/your child received
- Means by which you or a third-party Payer (Medicare/Medicaid/Other Private Insurance) can verify that services billed were actually provided **Your/Your Child's Health Information Rights**

Although your/your child's health record is the physical property of the facility, in this case, Pro Step Therapy, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your/your child's information
- Receive confidential communications of protected health information
- Inspect and copy your/your child's health record in accordance with law
- Request to amend you child's health record in accordance with privacy law
- Obtain an accounting of disclosures of your/your child's health information in accordance with privacy laws.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.
- Obtain a paper copy of the notice from us upon request

The right to make a request does not guarantee it will be granted, the request may be denied based on certain situations; including, emergency treatment, disclosures to the secretary of the Department of Health and Human Services, for example. All requests must be made in writing.

Our Responsibilities

- Maintain the privacy of your/your child's protected health information
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction.

We will not use or disclose your/your child's health information without your authorization, except as described in this notice:

We will use your/your child's health information for treatment. For example, information obtained will be recorded in your/your child's record and used to determine the best plan of care for your child. We will use your/your child's health information for payment, and we will bill your/your child's insurance carrier. We will also share evaluation and treatment information with the CDSA, treating physicians, and other healthcare professionals.