Mosaic Therapy Services, LLC
14700 Tamiami Trail N., Unit 1
Naples FL, 34110
239-249-5292

Therapy Intake Form

Today's Date _____

Client Name: _____ Nickname: _____

Date of Birth: _____ Age: _____ □ Male □ Female Diagnosis (if known): _____

Parent(s) / Guardians: _____

Address: _____City, State, Zip: _____

Phone #1:_____ Phone #2:_____

Email #1:_____ Email #2: _____

Emergency Contact: _____ Relationship to Child: _____ Phone: _____

Client's Physician: _____ Phone Number: _____

Language (s) spoken at home: _____

Describe your concerns:

_____

_____

_____

What are your goals for therapy? _____

_____

Payment Policy & Fee Schedule

Thank you for choosing our private practice to serve you. We are committed to providing you with the highest quality care. The timely payment of your bill is an integral part of our service and as such, this payment policy is an agreement between you and Mosaic Therapy for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family member. As a client of Mosaic Therapy Services, LLC you are required to carefully review and sign our payment policy.

Fee Schedule
(Effective 6/1/2022)

Service Fees:

Speech Therapy:
Initial Evaluation_____$300*
Therapy (60 min) _____ $120**
Therapy (45 min) _____ $92**
Therapy (30 min) _____ $65**

Orton Gillingham Tutoring:
Initial Evaluation _____ $120
60 minute session _____$75

PLAY Project _____ $400/month
- PLAY Project monthly rate includes:
  - 2-2.5 hrs of direct contact time
  - monthly video review and PLAY Plan
  - Availability throughout the month for additional phone consultation as needed

Consultative Services _____ $120/hour
Travel charge for school/daycare visits _____ $15/session

Prepay Discount (10 sessions): 5%, non-refundable. Credit cards will not be accepted for discounted sessions.

* Therapy session rate applies for any evaluation over 1 hour
** Session times include 5-10 minutes for cleanup and review with parents. Session times vary based on therapist recommendations and parent requests.

Please read the following information carefully:

All therapy fees are due prior to service, if a therapy package is purchased, or at the time of service, unless other financial arrangements are made.

Accepted payment methods:

☐ Check drawn on a U.S. Bank in U.S. funds. Checks should be made payable to Mosaic Therapy Services, LLC.

☐ Direct bank transfer paid via emailed invoice.

☐ Visa, Mastercard, or American Express

We will provide you with an invoice outlining the services rendered and the amount charged.

Please read and check of all boxes to acknowledge understanding and the sign below:

□ I understand that a parent or legal guardian must accompany clients who are minors. I also understand that this accompanying adult is responsible for payment of the account according to the payment policy outlined in this document.

□ Out-of-Network Coverage: Services at Mosaic Therapy Services, LLC may be covered at an out-of-network rate only. It is your responsibility to verify with your insurance company about your out-of- network outpatient speech or occupational therapy benefits before beginning therapy. Payment is due in full at the time of your session. It is your responsibility to submit your claim to your insurance company for reimbursement. It is also your responsibility to check the status of your claims and reconcile any discrepancies or problems that may arise with your reimbursement. You will receive a statement with the proper codes for diagnostic category and type of service provided, as well as other pertinent information needed for submission to insurance for reimbursement. *Reimbursement is considered a matter between you and your insurance company.*

□ I understand that if fees are not paid in full, treatment sessions may be postponed or cancelled until payment is received.

□ I understand that all returned checks will be subject to a $25 returned check fee.

□ I understand that I am responsible for all legal and collection fees, which Mosaic Therapy Services, LLC may incur if payment is not made in accordance with the terms and conditions herein.

□ I understand that refunds will be issued only in instances of overpayment. All refunds will be processed within 1 week after the overpayment is discovered on the client's bill or at the time the refund is requested. Refunds for payments made with a credit card will be credited back to the credit card used, all other refunds will be issued by a check.

□ I, understand that all cancellations require 24 hours notice and that there will be a $25 charge for any cancellations made less than 24 hours prior to your scheduled session.

□ I, _____, (client / guardian name) understand the payment policy and the risks of not adhering to it.

_____ _____
Print Name of Client Date of Birth

_____ _____
Signature of Client, Guardian or Responsible Party Relationship to Client

_____ _____
Private Practitioner / Witness Date

Payment Policy & Fee Schedule (Effective 6/1/2022)

Attendance / Cancellation Policy

Attendance and participation in therapy along with complete compliance with any associated home programs, are essential for therapeutic success.While Mosaic Therapy Services, 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 our office with advance notification for any cancellations resulting from a conflicting appointment, vacation, obligations for work or family, or any other event.

- A fee of $25 will be assessed if the following occurs for any reason:
    - If cancellations are made with less than 24 hours notice
    - If the client fails to show up for a scheduled appointment.
- We reserve the right to cancel future appointments or discharge the client at our discretion, based on the needs of Mosaic Therapy Services, LLC. Client’s attendance, including late cancellations and no shows will be taken into consideration.

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

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client

Authorization for Credit Card Use

By signing this form you give Mosaic Therapy Services, LLC permission to charge your credit card for the amount indicated on or after the indicated date. This is permission for current and future services as outlined in this agreement, and does not provide authorization for unrelated debits or credits to your account.

Your credit card information will be saved securely via IvyPay upon payment of your initial invoice.

I, _____ (client or parent/guardian name) authorize Mosaic Therapy Services, LLC to charge fees rendered for therapy services to the credit card provided via my IvyPay account.

I understand that the provided credit card will be charged for services rendered after each session and that I will receive a printed invoice as a receipt of payment.

Cardholder agrees to above terms. Please sign and date:

Print Name: _____ Signature: _____
Date: _____

Client Name: _____ Date of Birth: _____

Credit Card Authorization

I authorize Mosaic Therapy Services, LLC to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for therapy services, for the amount invoiced by the practice, and is valid for ongoing monthly and weekly services. I certify that I am an authorized user of the credit card provided and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Updated 1/1/2022

Consent for Services

□ I authorize Mosaic Therapy Services, 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 Mosaic Therapy in writing. In addition, Mosaic Therapy may terminate services by notifying me in writing.

□ I do not give my consent or am withdrawing my consent regarding Mosaic Therapy Services, LLC rendering evaluation and therapy services to the client named below.

_____ _____
Print Name of Client Date

_____
Client Date of Birth

_____ _____
Signature of Client or Legal Representative Relationship to Client

Acknowledgement That You Have Received Our HIPAA Privacy Notice

Mosaic Therapy Services, 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
- Test results
- Treatment notes
- Insurance information

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

□ I acknowledge that I have received a copy of Mosaic Therapy's HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.

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

□ I understand Mosaic Therapy cannot disclose my health information other than as specified in the notice.

□ I understand that Mosaic Therapy 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.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client

Please Note: It is your right to refuse to sign this Acknowledgement.
HIPAA Privacy Notice Acknowledgement

_____
Office Use Only

I tried to obtain written Acknowledgement of our Privacy Notice by the patient/legal representative noted above. It could not be obtained for the following reason(s)

- An emergency prevented us from obtaining acknowledgement.
- The individual was unwilling to sign.
- A communication barrier prevented us from obtaining acknowledgement.
- Other: _____

_____ _____

Staff Member Signature Date

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 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:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relative, 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 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 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 polices 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

Authorization to Exchange, Obtain or Release Information

Client Name: _____ Date of Birth: _____
Home Address: _____
_____

I _____ (client or family member) hereby grant Mosaic Therapy Services, LLC permission to communicate with the following person or agency:

Check entity with which we may share your information and provide name and relevant contact information):

☐ Physician: _____
☐ School:_____
☐ Other: _____
☐ Mosaic Therapy Collective providers (By checking this box, you consent to sharing information with providers within the Mosaic Therapy Collective for the purpose of inter-disciplinary collaboration and coordinating care.)

Information to Be Released:
□ Medical History
□ Therapy Evaluation
□ SLP □ OT Other: _____
□ Treatment Notes
□ SLP □OT Other: _____
□ School Records (Evaluations, IEP, academic reports, etc.)

For the Purpose Of: (check all that apply)
□ Coordinating care with other professionals
□ Providing continuity of services
□ Updating therapeutic progress
□ Other _____

□ **I grant permission to exchange information via written and mailed report, phone call, meeting, email, or fax.**
□ **I understand that unless revoked, this authorization will remain valid until written revocation of this authorization is presented.**

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client

Communication Preference Form

Client Name: _____ Date of Birth: _____

In an effort to ensure your privacy, it is important for us to understand your preferred method of receiving and communicating medical and administrative information pertaining to your therapy. As such, please indicate your communication preferences below.

For medical and administrative information pertaining to me such as clinical documentation, appointment reminders, therapy updates etc. I hereby grant permission to Mosaic Therapy to do the following:

Written Documentation and Verbal Information

□ I grant permission to provide me with written communication via unencrypted email service. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.

□ I grant permission to provide me with written communication (such as appointment reminders or cancellations) via text message. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.

□ I grant permission to provide me with written communication via USPS in an unmarked envelope.

□ I elect to receive clinical information in person or via telephone through the number provided.

□ I grant permission to leave relevant medical information on my answering machine or voicemail. I also give permission to release medical information pertaining to the client to the individuals listed below:

Sharing of Information

Individual's Name	Relationship to Client	Email Address and/or Phone Number
1.		
2.		

I understand that it is my responsibility to inform the practice of changes to my preferred contact information or my communication preferences, as well as, to revoke this authorization at any time.

_____ _____

Print Name of Client Date

_____ _____

Signature of Client or Legal Representative Relationship to Client