INFORMED CONSENT

Thank you for choosing Little Heroes, LCC for your child's physical therapy needs. Today's treatment session will take approximately 60 minutes. We realize that your child's care is extremely important and you may have several questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Our Therapist(s) are licensed by the State of Illinois as a Licensed Physical Therapist. Treatment practices, philosophy and plan initiations and risks will be discussed with you today.

Confidentiality and Emergency Situations

Your verbal communication and clinical records are strictly confidential except for: (1) information shared with our staff physical therapist(s), (2) information (diagnosis and dates of service) shared with your insurance company to process your claims, (3) information you and/or you child or children report about physical or sexual abuse; then, by Illinois State Law, I am obligated to report this to the Department of Children and Family Services, (4) where you sign a release of information to have specific information shared and (5) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community (911) for those services.

Signature(s)_____**Date:**_____

Financial/Insurance Issues

As a courtesy we may bill your insurance company, HMO, responsible party or third party payer for you. We ask that at each session you pay your co-pay and any patient deductible portion of the fee at the time of service. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover physical therapy, we require that you pay the balance due at that time. If you are unable to make the applicable payment at the time of service, a 5% cumulative fee will be applied weekly until payment has been made. In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Little Heroes, LLC.

Schedule: Treatment Session 15 minute unit = $38.75.
Schedule: Evaluation Session 15 minute unit = $56.25.

Signature(s)_____**Date:**_____

Financial Hardship

If you are experiencing financial difficulties and are unable to afford the cost of our services we have a "Financial Hardship Form" which may be filled-out. If you quality for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portions of the bill. Ask the front desk person for assistance.

Signature(s)_____**Date:**_____

We look forward to building a successful relationship with you that lasts a lifetime!

Late Policy

Being late by more than 15 minutes may require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient. If you are late for 3 sessions within a three (3) month period you will be required to pay for those missed minutes to be billed at $38.75 for each 15 minute increment, you may also lose your preferred allocated time on our therapist(s)'s schedule. Please be courteous and responsible. Thank you.

Signature(s)_____Date:_____

24 Hour Advance Notice Fee

If you wish to change or cancel an appointment we require a minimum **24-hour advance notice**. Anything less will result in a **$15 fee** charged to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.). We don't charge you the actual cost for that appointment but rather a mere **$15 fee**. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. If you miss 3 sessions within a two (2) month period without 24 hour advance notice, you may lose your preferred allocated time on our therapist(s)'s schedule. Please be courteous and responsible. Thank you.

Signature(s)_____Date:_____

Video Recording, Photography, and Archiving

Little Heroes, LLC will be using a video surveillance system within the clinic and each treatment room. This video will be used to ensure that ethical standards are followed and also serve as documented proof to any unethical or illegal matters, should they arise. Little Heroes, LLC will retain possession of these images unless required to surrender to the applicable law enforcement agencies upon their request. The therapist(s) may also occasionally use photography or camcorder videotaping for evaluation and re-assessment purposes to better document baseline function or improvements in motor function. These photos will remain part of your child's confidential file and will not be used for advertising or display. In order to comply with HIPPA Privacy Requirements, we are required to obtain parent or guardian permission. I hereby give Little Heroes, LLC permission to use photography or videotaping as an evaluation/re-assessment tool for _____. I understand these photos or videotape recordings will become part of their confidential file and will not be used for any other purposes. Photos or videotape may be shared with other health care professional as stated in "Authorization to Use or Disclose Protected Health Information" document.

Signature(s)_____Date:_____

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Consent For Treatment of Children and/or Adolesence

I/We consent that _____ maybe treated as a client by Little Heroes, LLC. At times it maybe necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for your children.

Signature(s)_____Date:_____

Acceptable Use of the Restroom Facilities

Should the need arise; it IS the responsibility of the parent to assist their child with use the restroom facility. If a parent is NOT present, our therapist will escort your child to the facility, but WILL NOT provide any assistance to your child. If your child is NOT yet toilet trained, it will be mandatory the parent or guardian be present at the clinic to change any soiled garments should the child have an accident. If a parent or guardian is NOT present, the therapist may choose to stop the treatment service and the remaining session will still be billed at the normal billable rate.

Signature(s)_____Date:_____

Notice of Privacy Practices and Client Rights

I/We have read and received a copy of the Notice of Privacy Practices document. I/We also understand that, if the need was to arise, Little Heroes, LLC or anyone affiliated with our organization may contact you at any phone number provided.

Signature(s)_____Date:_____

Important Notice From the Federal Government

It is unlawful to routinely avoid paying your co-pay, deductible or coinsurance payments . . . even if your doctor allows it. Unless you complete a *Financial Hardship* form and qualify for financial assistance under Federal Standards, you may **NOT** routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's - Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, and State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply. Please see contact info for more information. Office of Inspector General, Department of Health and Human Services. Contact by phone: 202 619-1343, by fax: 202 260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W., Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector General, 202 619-0089.

Signature(s)_____Date:_____

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