ISLAND THERAPY SOLUTIONS
5030 Anchor Way, Suite 7, 9 & 10
Christiansted, V.I. 00820
Phone: 340-719-7007
Fax: 340-719-6655

Thank you for choosing Island Therapy Solutions!

Please complete the following forms prior to your first appointment. You can send them via fax or email, or you can bring them with you to your scheduled appointment.

- Fax the forms to 340-719-6655
- Email to frontdesk@islandtherapysolutions.com

Required Forms Enclosed:

- Patient Information
- Cancellation Policy
- Financial Policy
- Informed Consent
- Particpation in Legal Action
- Notice of Privacy Practices Acknowledgment

CONFIDENTIAL
INITIAL EVALUATION

PART I: CLIENT INFORMATION Today's Date: _____

Client's Name: _____ Social Security No. _____

Date of Birth: _____ Age: _____ yrs. _____ month

Race: _____ Ethnicity: _____

CONTACT INFORMATION

Home Address: _____

Mailing Address _____

Email Address _____

Telephone number(s): (H) _____ (C) _____

(W) _____ (O) _____

Parent/Legal Guardian: _____

Emergency Contact: _____

GENDER

1. What is the client's current gender identity? (Check and/or circle ALL that apply)

☐ Male ☐ Female ☐ Transgender Male/Transman/FTM

☐ Transgender Female/Transwoman/MTF ☐ Genderqueer

☐ Additional category (please specify): _____ ☐ Decline to answer

2. What sex was assigned at birth? (Check one)
☐ Male ☐ Female ☐ Decline to answer

3. What pronouns does the client prefer? _____
He/Him; She/Her; They/Them

INSURANCE / SELF PAY

☐ **Self-Pay.** Initial here to acknowledge self-pay rates discussed. _____

OR

Primary Insurance Company: _____

Coverage Effective Date: _____ Ins. Contact Number: _____

Primary Card Holder/Guarantor Name: _____ DOB _____

Policy/Group Number: _____ Insured ID: _____

Address of Guarantor if Different from Above: _____

Patient Relationship to Guarantor: _____

Guarantor's Employer: _____

Secondary Insurance Company: _____

Coverage Effective Date: _____ Ins. Contact Number: _____

Guarantor's Name: _____ DOB _____

Policy/Group Number: _____ Insured ID: _____

Address of Guarantor if Different from Above: _____

Patient Relationship to Guarantor: _____

CUSTODY

Marital Status of Parents: ☐ Married ☐ Together ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Any prior, existing, ongoing or anticipated divorce or child custody proceedings? ☐ Yes ☐ No

If yes, what was the outcome relative to custody of the child. _____

Provide legal documents relative to the custody or legal guardship of the client, including DHS/DOH/BOC orders and releases.

CLIENT'S PERSPECTIVE

Please describe why you wish to be seen for an appointment and the problem(s) or symptom(s) you are currently having:

_____

_____

_____

_____

_____

_____

_____

_____

Please note any significant medical history and medications currently taking: _____

_____

_____

_____

_____

CONTRACTED SERVICES

SELECT AGENCY: Case Manager

___ BOC_____ ___DHS Voc Rehab_____ ___DOE_____

___DOH_____ ___DOH SERG_____

___DHS_____ ___OTHER _____

CANCELLATION POLICY

effective May 2019

It is the intention of all providers of Island Therapy Solutions to be flexible in meeting client and family needs. We have established the following cancellation policy that will hopefully be both flexible and reasonable as we work together to provide services. Our policy is based on the need to avoid unfilled appointments. This is especially important due to the number of families waiting to receive services. Therefore, our policy is as follows:

Cancellations must be made within 24 hours of the scheduled appointment time.

The late cancellation / no show fee for psychotherapy or counseling services is $25 per missed appointment.

The late cancellation / no show fee for psychiatric services is $75 per missed appointment.

The late cancellation / no show fee for testing is $25 per scheduled hour.

All late cancellation / no shows fees are due at or prior to the clients next scheduled appointment, with any provided within our organization.

Our main office number is 340-719-7007. Once we receive notice from you, we will contact the appropriate staff members. We believe that we are offering a very important service and sincerely hope that you would not feel the need to cancel, except in case of illness or family emergency. We will also extend the same courtesy to you, in the event that our staff needs to cancel for the same or similar reasons.

Upon cancellation notification, our office staff will contact the family to re-schedule on the next available appointment date. Please keep in mind that the appointment may not be in the same month as the originally scheduled appointment.

If a client has a standing appointment and they fail to show up for the appointment or call to cancel in a timely manner, they will automatically be removed from the schedule after 2 such occurrences in a 4-week period. The client may be placed back on the schedule once all applicable no show fees are paid. It is the client's responsibility to contact our office to be placed back on the provider's schedule.

Please feel free to contact us if you have any questions about this policy. We remain available to work with you in making the best possible use of this important service.

Client Name: _____ DOB: _____

Parent/Legal Guardian: _____ Date: _____

Witness _____ Date: _____

FINANCIAL POLICY

Thank you for choosing Island Therapy Solutions as the health care provider for you. Our practice is committed to providing the best possible care for your children. It is vitally important to our professional relationship that you have a clear understanding of our financial policy. Please take a moment to review. We require that you **read, agree to and sign** our financial policy prior to any treatment.

CONTRACTED INSURANCE CO-PAYMENT/CO-INSURANCE/DEDUCTIBLE

Island Therapy Solutions participates with all insurances that are contracted with VI Equicare, Inc., and will file all charges incurred with the appropriate claims office. We have agreed to accept the rates from these plans, however all co-Insurance and co-payments are your responsibility and are payable at the time of service as per your contractual obligation with your insurance company. Island Therapy Solutions is contractually obligated to collect this co-payment at the time of service. Island Therapy Solutions will collect in full any amount incurred per visit until your deductible is met.

Today's health insurance policies and coverage offers more options than ever. Each patient is responsible for knowing his/her plan benefits package, co-payment, co-insurance deductible, non-covered services and restrictions.

NON-CONTRACTED INSURANCES

If you do not participate with your insurance plan, payment in full is expected at the time of service. We will provide you with a claim form for filing with your insurance company.

SECONDARY INSURANCE

Have more than one insurer **DOES NOT** necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We will bill your secondary carrier as a courtesy. You are responsible for any balances after your insurance has cleared.

NO INSURANCE

Full payment is due at the time of service. If you are unable to pay your balance in full, please make arrangements with our billing department prior to your scheduled appointment. Failure to make prior arrangements for payment, thus requiring us to bill the visit fee will result in additional fees (*please see below).*

PAYMENT/SERVICE CHARGE FEES

We accept cash, bank certified check, debit and credit cards with the Visa and MasterCard logo.

In the event that there are any outstanding payments after service is performed there will be a service charge fee of $30.00 is payment is not made by the end of the business day.
There will be a $50.00 service charge for all returned checks.

Any outstanding balances are due within 30 days. If you are experiencing circumstances out of your control, please call our office and we will be happy to make payment arrangements. All accounts

with unpaid balances over 60 days will be assessed a $30.00 monthly statement fee. All balances that reach 90 days past due will be sent to a collection agency. Should your account be sent to a collection agency you will be financially responsible for any collection fees and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

Thank you for your understanding of our financial policy. If you have any questions or concerns, please feel free to discuss them with our billing department.

I have read and fully understood the Financial Policy of Island Therapy Solutions.

Print Name _____ Date _____

Signature _____ Date _____

ISLAND THERAPY SOLUTIONS

CONSENT FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Client Name:_____ Date of Birth:___/___/____
(Last) (First) (Middle)

Home Address:_____

I understand that any of my personal health information (other than notes from any therapy sessions with a counselor) may be used and/or disclosed by Island Therapy Solutions for purposes of carrying out treatment, obtaining payment, and carrying out other health care operations of the organization. I have received a copy of Island Therapy Solutions' Notice of Privacy Practices, which I understand provides a more complete description of possible uses and disclosures of my health information. I understand that it is my right to review the Notice of Privacy Practices prior to signing this consent form. I also understand that the terms of the Notice of Privacy Practices may change in the future and that I may obtain a copy of the Notice of Privacy Practices that is in effect at any given time (whether or not it has ever been changed) by requesting a copy at the front desk.

I understand that I have a right to request how my health information is used or disclosed to carry out treatment, payment or other health care operations, but I also know that Island Therapy Solutions is not required to agree to any such request. I understand that, if Island Therapy Solutions agrees to my request, the restriction will be binding on Island Therapy Solutions.

I understand that I have a right to revoke this consent by filling out and signing a written revocation form which is available at the front desk, from the Office Manager. I also understand that, if I choose to revoke my consent, it can only be revoked to the extent that Island Therapy Solutions has not acted in reliance upon the consent.

By signing below, I hereby voluntarily and knowingly consent to allow Island Therapy Solutions and any of its physicians, counselors, employees and/or agents, to use and/or disclose my health information as deemed appropriate to carry out treatment, payment and/or other health care operations of the organization.

Dated:_____ _____
(Signature of Client or Legal Representative)

If you are the legal representative of the client, please check off the basis for your authority:

- _ Power of Attorney (attach copy)
- _ Guardianship Order (attach copy)
- Parent of Minor
- Other_____

Today's Date: _____

I have been a patient at Island Therapy Solutions before today: (circle one) Yes No

How did you hear about us?

Please check all that apply.

- ☐ **Friend/Family**:
- ☐ **Facebook**
- ☐ **Website**
- ☐ **Internet Search**
- ☐ **Professional Referral: Please specify**_____
- ☐ **Phonebook**
- ☐ **Billboard**
- ☐ **Newspaper**
- ☐ **Walked By**
- ☐ **Radio**
- ☐ **Community Event: Please specify**_____
- ☐ **Other**_____

PROVIDER PARTICIPATION IN LEGAL ACTION

By signing this form, I hereby attest that I am not seeking services from Island Therapy Solutions, in pursuit of or in connection with ongoing or pending legal action.

Note that if services are rendered for reasons not exclusively related to the diagnosis and treatment of a recognized mental health condition, that the insurance company may not pay for these services, or they may request reimbursement for claims previously paid.

Should you enter into litigation during the course of your care at Island Therapy Solutions, please notify us immediately. There are fees associated with our provider's participation or attendance in any court proceedings. Those fees are the sole responsibility of the client and can be made available upon request.

Please initial the appropriate response below and sign and date the form.

_____ I am **not** currently involved or anticipate being involved in any legal proceedings.

_____ I am currently involved or anticipate being involved in legal proceedings.

Print Name _____ Date _____

Signature _____ Date _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT COVER SHEET

Please have the consumer complete this cover sheet, and then tear off this cover sheet and file it in the client's medical record.

I, _____ (have client write name, or request staff assistance to do so), hereby acknowledge that I have received this Notice of Privacy Practices, with an effective date of August 6, 2020.

_____ _____

CONSUMER SIGNATURE
LEGAL GUARDIAN SIGNATURE
OR PARENT OF MINOR CHILD
SIGNATURE

DATE

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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.
This Notice describes how Island Therapy Solutions protects the health information it has about you. When this information becomes a part of your record, it serves as a basis for developing a plan of services for you, a means of communicating with the health professionals who contribute to your care and a source of verification that services were provided. This Notice also describes your legal rights with regard to your personal health information. We are required by federal law to maintain the privacy of this personal health information and to provide you with notice of our legal duties and privacy practices.

HOW ISLAND THERAPY SOLUTIONS MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU
Island Therapy Solutions may use and disclose your protected health information to physicians, nurses, dietitians, therapists, or others who are involved in your care and who will provide you with treatment or services. Protected health information includes information that we create or receive that identifies you and your past, present or future health status or care, the provision of care, or payment for that health care. The primary reasons for which we may use and disclose your protected health information are as follows:

1. **To provide treatment or services to you.** This refers to the provision and coordination of your care by your ABA Specialist, or your doctor, therapist or other health care provider. For example, if you need assistance with your speech, we may contact a speech therapist to arrange services for you.
2. **For payment of services provided to you.** Your protected health information will be used to obtain payment for services you receive. This may include information that your health insurance plan may require before it approves or pays for health care services. For example, obtaining approval for a hearing aid may require that your health information be disclosed to Medicaid. We may also provide your health information to our billing department to prepare a bill to send to your insurance company, including Medicare or Medicaid, for payment for services provided.
3. **For healthcare operations.** We may use or disclose your protected health information to support the business activities of our offices, including quality assessment, employee review activities, compliance reviews, and accreditation surveys. These activities are referred to as "health care operations".

The following are circumstances where Island Therapy Solutions may use or disclose your health information without first obtaining your Authorization for purposes other than treatment, payment, or health care operations.

1. For Permitted or Required by Law Activities.
2. Appointment Reminders/ Other Health Services: We may use or disclose your health information to contact you at the address and/or telephone number you give us to provide appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to you.
We may also use and disclose your health information for other marketing activities. For example, your name and address may be used to send you a newsletter about the services we offer. We may also send you information about products or services that we believe may be beneficial to you.
3. Communication with Family or Personal Representative: Unless you object, we may disclose to a member of your family, a relative, a close friend or a person you identify, your health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
In the event of your death, we may share your health information with family members and others who were involved in your care, unless you have previously expressed your wish that we not do so.

4. Emergencies: We may use or disclose your health information in an emergency treatment situation. If this happens, we shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment.
5. Communication Barriers: We may use and disclose your health information if we attempt to obtain consent from you but are unable to do so due to substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances.
6. Public Health: As required by law, we may disclose your health information to a public health or legal authority charged with preventing or controlling disease, injury or disability. For example, we may be required to disclose the fact that you have a communicable disease.
7. Health Oversight: We may disclose health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
8. Abuse or Neglect: We may disclose your health information to the governmental entity or agency authorized to receive such information if we believe that you have been a victim of abuse, neglect or domestic violence.
9. Food and Drug Administration: We may disclose your health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance.
10. Legal Proceedings: We may disclose health information in response to an order of a court or administrative tribunal
11. Law Enforcement: We may disclose limited health information for law enforcement purposes to identify or locate a victim, suspect, fugitive or material witness, a missing person, or for reporting a crime that occurred on our property or that may have caused a need for emergency services
12. Coroners, Funeral Directors, and Organ Donation: We may disclose health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose medical/health information to a funeral director to permit the funeral director to carry out his lawful duties. We may disclose such information in reasonable anticipation of death. Health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes
13. Workers' Compensation: Your health information may be disclosed by us as authorized to comply with workers compensation laws and other similar legally-established programs
14. Serious Threat to Health or Safety: We may use or disclose health information if we believe in good faith that it is necessary to lessen or prevent a serious and imminent threat to the health and safety of a person or the public
15. Specialized Government Functions: Your personal health information may be disclosed to other entities that are covered by this law that are government programs providing public benefits. For example, we may share information with the Department of Social Services to determine your spenddown requirements, or with the Department of Health and Senior Services to coordinate care for a child with special health needs
16. Inmates: If you are an inmate of a correctional institution or in the custody of law enforcement, we may release health information about you as may be necessary for the institution to provide care to you, to protect your health and safety or the health and safety of others, or for the safety and security of the institution.
17. Immunization Records: We may disclose proof of immunizations to schools; however, we will seek to obtain the written or oral agreement of the parent, guardian, emancipated minor, or person acting in loco parentis.

The following are circumstances where Island Therapy Solutions may use or disclose your health information only after obtaining your authorization.

1. **Most Uses and Disclosures of Psychotherapy Notes:** Psychotherapy notes are notes recorded by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group or family counseling session that are kept separately from the rest of your health record. These notes will typically not be used or disclosed without your Authorization. However, psychotherapy notes do not include medication prescription and monitoring, the times of your counseling session, the type of treatment furnished, results of tests, or a summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress, which are subject to restrictions that apply to the use or disclosure of those records.
2. **Marketing:** If Island Therapy Solutions wants to include a photograph of you or to obtain a quote from you for inclusion in the Agency's annual report, or on its website, or in other media presentations, we will ask for your Authorization to do so. We will also obtain your Authorization before communicating with you about a health-related product or service in a situation in which Island Therapy Solutions will receive payment in exchange for the communication, with the exception of communications with you about government and government-sponsored programs or general health promotions.
3. **Communication with Others Who May Not Be Covered by the Federal Privacy Law:**
    a. To refer you to other agencies that may be able to provide services that you express an interest in receiving such as Vocational Rehabilitation.
    b. To provide your attorney with information you would like to share with him/her
    c. To communicate with the public schools to coordinate school-related goals with your plan of care.

d. To discuss your needs with a member of the General Assembly for the purpose of education related to funding for programs.

2. **Sale of Protected Health Information:** To communicate with others regarding your protected health information if Island Therapy Solutions or one of its Business Associates will receive direct or indirect payment in exchange for the disclosure of your protected health information. This does not apply to public health activities, for purposes related to your treatment or for payment of services provided by Island Therapy Solutions, for research purposes if the payment is cost-based, for services rendered by a Business Associate if the payment is cost-based, for providing you access to your protected health information, or as required by law.

You may revoke an authorization, in writing, at any time except to the extent that we have already taken action in good faith relying on the authorization. Any other uses and disclosures not specified in this Notice require an authorization.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ISLAND THERAPY SOLUTIONS MAINTAINS ABOUT YOU

Following is a statement of your rights and how you may exercise these rights.

You have the right to inspect and copy your protected health information. You may inspect and obtain a copy of health information about you that is contained in a designated record set for as long as we maintain the health information. A "designated record set" contains medical and billing records about you that we maintain and any other records that we use for making decisions about you. You may be charged a fee for the costs of copying, mailing or other such costs associated with your request. *Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and health information that is subject to law that prohibits access to health information.* If your request for access is denied, you may request that the decision be reviewed. Requests for access should be directed *in writing* to the Privacy Officer listed in this notice.

If the protected health information that you are requesting to copy is maintained electronically, you may request an electronic copy of such information and we will provide you with access in the electronic form and format requested if it is readily producible in such form and format. If it is not, we will produce it in a readable electronic form and format as we mutually agree. We will act on your request within 30 days of receipt, unless it becomes necessary to request an additional 30-day extension. We will let you know the reason for the delay and the expected date of completion.

If you request transmittal of an electronic copy of your health information to another person, you must designate in a written document signed by you the person to receive such information and where to send the information.

Island Therapy Solutions may charge a reasonable cost-based fee for the supplies to create a paper copy or portable electronic media, the cost of postage and if you want the portable media mailed to you. There are no fees for handling and retrieval.

You have the right to request a restriction of your health information. This means you may ask us not to use or disclose any part of your health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request, except as stated below. If we believe it is in your best interest to permit use and disclosure of your health information, your health information will not be restricted. If we do agree to the requested restriction, we may not use or disclose your health information in violation of that restriction unless it is needed to provide emergency treatment. *To request a restriction, you must make your request in writing.* You must tell what information you want to restrict; whether you want to limit our use, disclosure or both; and to whom you want the restrictions to apply. We will not agree to restrictions on uses or disclosures that are legally required.

If you request a restriction on the disclosure of protected health information to a health plan, and the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the information pertains solely to a health care item or service for which you or a person on your behalf paid the covered entity out-of-pocket in full, we will restrict the disclosure of protected health information, but it is your responsibility to notify other providers with whom we may disclose your information of this restriction.

You have the right to request to receive confidential communications from Island Therapy Solutions by alternative means or at an alternative location. Communications involving personal health information may be provided to you at an alternative location or by an alternative means of communication. We will accommodate reasonable requests if you clearly state on the request that disclosure could endanger you. To request confidential communications, *you must make your request in writing* to our Privacy Officer and specify how or where you wish to be contacted.

You may have the right to request an amendment to your health information. If you believe your personal health information is incorrect or that an important part of it is missing, you may request an amendment of health information about you for as long as we maintain this information. *You must request the amendment in writing and specify the reason for your request.* We may deny your request if the information was not created by us, is not part of the