Consent to Treat, Bill Insurance & Privacy Form

Thank you for choosing North Oakland Autism Center!

**Please carefully review each area so we may provide optimal care, appropriately bill your insurance company, and securely share your information.*

Consent for Treatment~

By signing this form, I consent to and authorize North Oakland Autism Center to deliver ABA Therapy Services. I understand that I may request a copy of my child's current treatment plan at any time. I also understand that my provider is available to review my child's ABA treatment plan and/or progress at any time. I also have the right to refuse any treatment.

Benefits~

I authorize the release of any medical information necessary to process insurance claims for ABA Therapy services provided. I also authorize payment of benefits directly to North Oakland Autism Center for services provided.

Insurance~

We participate with many insurance plans. If you are not insured by an in-network insurance provider or do not have insurance coverage, payment in full is expected at each visit. Please contact your insurance company with any questions you may have regarding your specific ABA Therapy coverage.

Payment~

I understand that I am financially responsible to make monthly payments for my deductible, co-insurance, co-pays, and any private pay services. Although we assist in determining your specific coverage; it is ultimately the subscriber's responsibility to understand their insurance coverage. All co-payments, co-insurance and deductibles will be billed at the end of each month, and are due within five (5) calendar days for continued services. Payment may be made in cash, check or credit card, including an HSA Cards. I understand a late fee may be applied to any outstanding invoices. I also understand there will be an additional $35 processing fee for collection accounts and/or bounced checks. I understand that I need to notify NOAC of any insurance changes as soon as possible to ensure continuation of care.

Non-Covered Services~

Some of the services you may request will be non-covered services, as certain service may not be considered medically necessary by your insurance company. Some examples are attending IEP Meetings, consulting and/or training school staff to work with your child. These services may be available, but are billed at our hourly private pay rate.

Patient Authorization~

I authorize North Oakland Autism Center to send copies of my records to other physicians/service providers as needed for continuity of care. I also agree that NOAC can release my medical records to accrediting or regulatory agencies, if those agencies request my records, and if the law allows these agencies to see my records.

Authorization to Communicate Private Health Information~

I authorize North Oakland Autism Center to leave messages on my voicemail or with anyone who may answer my phone numbers listed on my intake paperwork. I also authorize NOAC to email and/or text my cell phone any necessary communications about my child. NOAC may also share private health information with family or caregivers who may pick up/drop off my child if we feel it's in your child's best interest. This means staff will answer family/caregiver questions, if the inquiry is made on behalf of the child. **If you do not agree with our policy, please provide the names of individuals with whom we should not share information below.**

Patient's Right to Privacy~

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) we have a HIPAA Notice of Privacy Practices on display in the reception area. This document describes in detail how information about clients can be used within our office and with others who may need information for treatment, payment, and/or health care operations. If we were to disclose your information for any other reason, we would first need your written approval. A printed copy of the HIPAA notice will be provided upon request.

By signing below, I attest I have read the above and authorize North Oakland Autism Center to treat, bill and share my medical information as discussed above.

Signature of Patient / Parent or Guardian

X_____Date_____

Signature of Patient / Parent or Guardian

X_____Date_____