Informed Consent for Occupational Therapy and Telehealth Services

Neurospace LLC
Phone: 734-707-7219
Email: hello@neurospaceot.com

Client Full Name: ____

Date of Birth: ____________________

By signing below, I acknowledge and agree to the following:

- I consent to occupational therapy evaluation and treatment provided by a licensed occupational therapist at Neurospace LLC, within the scope of occupational therapy practice and in accordance with applicable state laws.
- I understand the nature and purpose of occupational therapy services and have had the opportunity to ask questions and discuss alternative approaches, including in-person services when clinically appropriate and available.
- I understand that occupational therapy services may be provided in person, via telehealth, or through a combination of both, depending on clinical appropriateness and availability.
- I understand that participation in occupational therapy may involve physical, emotional, or functional challenges, and that telehealth services may involve additional risks such as technology failures, interruptions, or delays in communication.
- I understand that participation in occupational therapy, particularly in home or community settings or during telehealth sessions, may involve activities within my personal environment. I acknowledge that I am responsible for maintaining a reasonably safe environment during sessions and for following recommended safety guidelines to the best of my ability.
- I understand that the therapist will provide guidance to support safety, but cannot control all aspects of my environment, and that participation in activities carries some inherent risk, including the possibility of injury or damage to personal property
- I understand that telehealth occupational therapy services are delivered using secure, HIPAA-compliant audio and/or video communication technology and that there may be limitations related to the virtual format, including limitations in physical observation or hands-on intervention.

- I understand that occupational therapy and telehealth services are provided in accordance with applicable state laws based on my physical location at the time of service.
- I understand that for telehealth sessions, I am responsible for participating from a private and safe location and for using a device and internet connection that reasonably support telehealth services.
- I understand that in the event of an emergency during a telehealth session, I may be directed to contact local emergency services, and that the therapist may take reasonable steps to assist in contacting emergency support if needed.
- I understand that my health information will be kept confidential in accordance with applicable laws, with certain exceptions, including situations involving risk of harm to myself or others, suspected abuse or neglect, or as otherwise required by law.
- I understand that communication outside of scheduled sessions (such as email) may be used for administrative or care coordination purposes and may carry some privacy risk.
- I understand that I am responsible for reviewing and adhering to Neurospace LLC's financial policies, including payment for services, and that I have had the opportunity to review these policies.
- I understand that I may refuse or discontinue any evaluation, treatment, or mode of service delivery, including telehealth, at any time.
- I understand that outcomes of therapy cannot be guaranteed

By signing this form, I confirm that my questions have been answered to my satisfaction and that I voluntarily consent to receive occupational therapy services, including telehealth services, from Neurospace LLC.

Client / Guardian Signature: ______________________________

Date: ______________

Notice of Privacy Practices

Neurospace LLC
Phone: 734-707-7219
Email: hello@neurospaceot.com

Effective Date: ______________________________

This notice describes how health information may be used and disclosed and how you can access this information. Please review it carefully.

I. OUR PLEDGE REGARDING HEALTH INFORMATION

Neurospace LLC understands that health information about you and your healthcare is personal and is committed to protecting your protected health information ("PHI").

We respect that your health information is personal and that you have a right to understand and make informed choices about how it is used.

We create and maintain records of the care and services you receive from this practice. These records are used to provide you with care, coordinate services, and comply with legal and professional requirements.

This Notice applies to all records of your care maintained by Neurospace LLC. It describes how we may use and disclose your health information, your rights regarding that information, and our responsibilities related to its protection.

We are required by law to:

- Maintain the privacy of your PHI
- Provide you with this Notice of Privacy Practices
- Follow the terms of the Notice currently in effect

We may change this Notice at any time. Any changes will apply to all PHI we maintain. The updated Notice will be available upon request and on our website.

II. HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Treatment, Payment, and Health Care Operations

Federal law allows healthcare providers to use and disclose PHI without written authorization for purposes of treatment, payment, and healthcare operations.

Examples include:

- Providing, coordinating, or managing your occupational therapy services
- Consulting with other licensed healthcare providers involved in your care
- Submitting claims and processing payment
- Practice operations such as supervision, quality improvement, and compliance activities

Disclosures for treatment purposes are not subject to the minimum necessary standard, as access to complete information may be required to provide appropriate care.

Use of Third-Party Services

Neurospace LLC may use secure third-party service providers (such as electronic health record systems, billing platforms, and communication tools) to support operations. These providers are required to maintain appropriate safeguards and, when applicable, Business Associate Agreements to protect your information.

Lawsuits and Legal Proceedings

We may disclose PHI in response to a court or administrative order, subpoena, or other lawful process, as permitted by law. When possible, we will make reasonable efforts to notify you or seek protective measures.

III. USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

We will obtain your written authorization before using or disclosing your PHI for purposes not described in this Notice, including:

- Marketing activities
- Sale of PHI

You may revoke an authorization at any time in writing, except to the extent action has already been taken based on the authorization.

IV. USES AND DISCLOSURES THAT DO NOT REQUIRE AUTHORIZATION

We may use or disclose your PHI without authorization as permitted or required by law, including:

- Public health and safety reporting (e.g., abuse or neglect reporting)
- Health oversight activities (audits, investigations)
- Law enforcement or legal proceedings
- Coroners or medical examiners
- Workers' compensation claims
- Appointment reminders and information about services we offer

---

V. DISCLOSURES WITH OPPORTUNITY TO OBJECT

We may share PHI with family members, caregivers, or others involved in your care or payment for care unless you object. In emergencies, consent may be obtained retroactively when appropriate.

Disclosures to employers or agencies related to disability, leave, or benefits determinations will generally require your authorization. Neurospace LLC does not provide daily treatment notes directly to employers or third parties.

VI. YOUR RIGHTS REGARDING YOUR PHI

You have the right to:

- Request restrictions on certain uses and disclosures
- Request confidential communications
- Access and obtain copies of your health records

- Request amendments to your records
- Receive an accounting of certain disclosures
- Obtain a paper or electronic copy of this Notice

Requests must be submitted in writing at the email listed at the top of this form. We will respond within the timeframes required by law.

VII. ELECTRONIC COMMUNICATIONS

Electronic communication (such as email or text messaging) may involve some privacy risk. By choosing to communicate electronically, you acknowledge and accept these risks. You may request alternative communication methods at any time.

VIII. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Neurospace LLC by contacting the Privacy Officer listed below. You may also file a complaint with the U.S. Department of Health and Human Services. You will not be penalized or retaliated against for filing a complaint.

Privacy Officer
Rachel Robertson, OTR/L
Contact: hello@neurospaceot.com

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of Neurospace LLC's Notice of Privacy Practices and have had the opportunity to ask questions.

Client / Guardian Signature: ______________________________

Date: ______________

Payment & Financial Responsibility Policy

Neurospace LLC
Phone: 734-707-7219
Email: hello@neurospaceot.com

Payment Methods

Neurospace LLC accepts cash, check, credit card, debit card, including most HSA and FSA cards, and select insurance plans. Accepted payment methods and card brands may vary.

Insurance Coverage

Neurospace LLC accepts Michigan Auto No-Fault insurance for conditions resulting from a motor vehicle accident and select Blue Cross Blue Shield (BCBS) plans.

As a courtesy, Neurospace LLC may submit claims for accepted insurance plans when applicable; however, clients remain responsible for understanding their benefits and for all charges not covered by insurance.

Clients are financially responsible for all services provided, including amounts not covered, denied, or applied to deductibles, copays, or coinsurance. Coverage estimates are not a guarantee of payment.

For insurance plans not accepted by Neurospace LLC, superbills may be provided upon request for potential out-of-network reimbursement. Reimbursement is not guaranteed. Clients are responsible for verifying benefits, obtaining required authorizations, and payment at the time services are rendered.

Cancellation & Missed Appointments

Cancellations made with at least 24 hours' notice will not incur a fee.

Late cancellations or missed appointments may be charged the full cost of the scheduled appointment. Insurance does not reimburse for late cancellation or missed appointment fees.

Payment Timing & Outstanding Balances

Payment is due at the time services are rendered unless prior arrangements have been made in writing.

Clients are responsible for keeping a valid payment method on file when required.

Outstanding balances may result in suspension of services and may be referred to collections if unresolved. Clients will be notified in writing prior to any collection activity.

Service Rates & Additional Charges

Service rates are determined by Neurospace LLC and may vary based on service type, duration, location, travel requirements, or client-requested professional time outside of scheduled sessions. Rates are subject to change with notice.

Acknowledgment

By signing below, I acknowledge that I have received, read, and understood this Payment & Financial Responsibility Policy and agree to its terms.

Client / Guardian Signature: ______________________________

Date: ______________

Client Rights & Responsibilities Policy

Neurospace LLC

Neurospace LLC is committed to providing occupational therapy services in a manner that is respectful, collaborative, and consistent with applicable laws and professional standards. This policy outlines your rights as a client and your responsibilities as a participant in services.

CLIENT RIGHTS

As a client of Neurospace LLC, you have the right to:

1. Respectful, Non-Discriminatory Care

Receive services in an environment that is respectful, inclusive, and free from discrimination based on race, color, ethnicity, national origin, religion, sex, gender identity or expression, sexual orientation, age, disability, neurotype, marital status, or any other characteristic protected by law.

2. Dignity, Autonomy, and Choice

Be treated with dignity and respect, and to participate actively in decisions about your care. You have the right to make informed choices, including the right to decline or discontinue services at any time.

3. Informed Consent

Receive clear information about the nature and purpose of occupational therapy services, including potential benefits and limitations, before consenting to evaluation or treatment.

4. Privacy and Confidentiality

Have your protected health information kept private and confidential, in accordance with state and federal law, including HIPAA. You have the right to review Neurospace LLC's Notice of Privacy Practices and to ask questions about how your information is used or shared.

5. Access to Your Records

Request access to, or copies of, your occupational therapy records, subject to applicable legal requirements and timelines.

6. Clear Communication

Ask questions, request clarification, and receive information in a way that supports your understanding, including reasonable accommodations when needed.

7. Coordination of Care (With Permission)

Authorize or decline communication with other providers, caregivers, or organizations involved in your care through a written Release of Information.

8. Express Concerns or Complaints

Raise concerns, provide feedback, or file a complaint about services without fear of retaliation. You may also seek information about external complaint or regulatory processes upon request.

CLIENT RESPONSIBILITIES

As a client of Neurospace LLC, you are responsible for:

1. Providing Accurate Information

Sharing relevant and accurate information about your health, goals, and circumstances to the best of your ability, so services can be provided safely and effectively.

2. Participation in Services

Participating in therapy to the extent you are able, communicating preferences, needs, and boundaries, and collaborating in goal-setting and planning.

3. Respectful Conduct

Treating therapists and staff with respect. Neurospace LLC reserves the right to pause or discontinue services if behavior becomes unsafe, threatening, or significantly disruptive.

4. Attendance and Communication

Making reasonable efforts to attend scheduled appointments and providing advance notice if you need to cancel or reschedule, in accordance with clinic policies.

5. Financial Responsibility

Understanding and complying with the Payment & Financial Responsibility Policy, including responsibility for charges not covered by insurance.

6. Updating Information

Notifying Neurospace LLC of changes to contact information, insurance coverage, or other circumstances that may affect services.

7. Technology & Telehealth Participation (If Applicable)

Using telehealth technology responsibly and communicating promptly if technical or safety issues arise during remote sessions.

QUESTIONS OR CONCERNS

If you have questions about your rights or responsibilities, or concerns about your care, you are encouraged to discuss them directly with your occupational therapist or contact Neurospace LLC using the contact information provided.

Bill Insurance

Consent To Bill Insurance

I authorize **Neurospace LLC** to submit claims to my insurance company for occupational therapy services I receive.

By signing below, I understand and agree to the following:

- Neurospace LLC may release necessary health information to my insurance company for purposes of billing and payment.
- Insurance benefits are determined by my insurance plan, not by Neurospace LLC.
- I am responsible for all charges not covered by my insurance, including deductibles, copays, coinsurance, denied claims, or services deemed non-covered.
- If my insurance does not pay for services, or if I do not have active insurance coverage, I am responsible for payment in full.

I also understand that:

- I have the right to refuse or discontinue any treatment or procedure.
- I have the right to discuss recommended services with my occupational therapist.
- I may ask questions about costs before services are provided.

Insurance Information

Primary Insurance Plan Name:

____

Effective Date: ______________________________

Are you the primary policyholder?
☐ Yes ☐ No

If no, please provide the following:

Name of Primary Policyholder: ___________________________

Date of Birth: ___________________

Relationship to Policyholder:

Member ID Number: ____________________

Secondary Insurance (if applicable)

(Leave blank if none)

____

____

____

____

Authorization

By signing below, I confirm that the information provided is accurate to the best of my knowledge and that I authorize **Neurospace LLC** to bill my insurance for services rendered.

Client / Guardian Signature: ____

Date: ____________________

ROI

Authorization For Release Of Information

Client Full Name: ______________________________

Date of Birth: ____________________

I authorize the person(s) or organization(s) listed below to release my protected health information (PHI) to the person(s) or organization(s) listed below.

1. Information to Be Released

Please describe the specific information to be shared.
(You may write “all occupational therapy records” or list specific information.)

____

____

2. Person(s) or Organization(s) Releasing Information

Name of person / organization: ______________________________
Address (if applicable: ______________________________
Phone: ____________________ Fax (if applicable): ____________________
Email: ______________________________

Name of person / organization: ______________________________
Address (if applicable: ______________________________
Phone: ____________________ Fax (if applicable): ____________________
Email: ______________________________

3. Person(s) or Organization(s) Receiving Information

Name of person / organization: ______________________________
Address (if applicable: ______________________________
Phone: ____________________ Fax (if applicable): ____________________
Email: ______________________________

Name of person / organization: ______________________________
Address (if applicable: ______________________________
Phone: ____________________ Fax (if applicable): ____________________
Email: ______________________________

4. Purpose of the Disclosure

(e.g., coordination of care, consultation, benefits determination, client request)

---

5. Sensitive Information (Initial if applicable)

I understand that this authorization may include information related to **mental or behavioral health services**, and I consent to the release of this information if it is included above.
Client initials: ________

(Note: Neurospace LLC does not provide substance use disorder treatment governed by 42 CFR Part 2.)

6. Your Rights Regarding This Authorization

By signing this form, I understand that:

- I am not required to sign this authorization.
- My decision not to sign will not affect my ability to receive services or payment for services.
- I may revoke this authorization at any time by submitting a written request to **Neurospace LLC**.
- Revocation will not affect information already disclosed under this authorization.
- Information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws.
- I have the right to receive a copy of this signed authorization upon request.

7. Expiration of Authorization

This authorization will expire on: ________________________
If no date is listed, this authorization will expire **one (1) year from the date of signature**.

8. Acknowledgment

I certify that I have read and understood this Authorization for Release of Information and have had the opportunity to ask questions.

Client / Guardian Signature: ____

Date: ____________________