THRIVE BEHAVIORAL CONSULTANTS
GREENVILLE, SC

Name _____SS # _____ DOB _____

Parents/Guardian _____

Patient address _____

City _____ State _____ Zip code _____

Phone _____ Email _____

Insurance Company _____

Insured's Name _____ DOB _____

ID # _____ Group # _____

Insurance Company _____

ID # _____ Group # _____

Physician name _____ Diagnosis _____

Hours Available for ABA during School Year
M _____T _____ W _____ T _____ F _____ S_____ S_____

Hours Available for ABA therapy during Summer
M_____ T_____ W_____ T_____ F_____ S _____ S_____

Current Medications _____

Personal Allergies _____

Health History _____

****Please provide copy of assessments for Speech therapy, occupational therapy or IEP

The above information is correct to the best of my knowledge. I authorize my insurance benefits to be paid directly to Thrive Behavioral Consultants. I hereby accept responsibility for any services proved not covered by my insurance in addition to all copayments, coinsurance and deductibles for services that were rendered. Thrive Behavioral Consultants participates with traditional Medicaid and Claims Benefit Administrators (Blue Cross Blue Shield PPO). I authorize Thrive Behavioral Consultants to release any information required to process my claims.

Parent/Guardian _____ Date _____

THRIVE BEHAVIORAL CONSULTANTS
GREENVILLE, SC
PATIENT CONSENT

Consent for Treatment of a Minor
As the parent or legal guardian of the patient, I do hereby give my consent and authorize treatment.

Consent to Bill I give my permission to have evaluation and assessment services billed to my insurance company. In addition to any medical information necessary to process the insurance claims and assign payments to Thrive Behavioral Consultants. We participate with Traditional Medicaid and Claims Benefit Administrators (CBA) subsidy of Blue Cross Blue Shield.

Notice of Privacy Practices I acknowledge that I have been notified of Thrive Behavioral Consultants' Notice of Privacy Practices, which describes the ways in which the provider may use and disclose my health information for its treatment and payment/health care operations and other described and permitted uses and disclosures. I understand that I may contact the HIPPA compliance officer in regards to a question or complaint. To the extent permitted by the law, I consent to use and disclose my information for the purposes described in practice's Notice of Privacy.

HIPAA CONSENT We are unable to give out confidential patient information to any party over the phone of in person without your written authorization. If you wish to discuss your personal medical information over the phone or in person with someone other than yourself, please complete the authorization below.

Name _____ Phone _____Relationship _____

Media Consent I authorize Thrive Behavioral Consultants and its representatives the irrevocable right to use my child's picture or video in all forms at their discretion and I waive the right to approve the finished product. The picture can be used for evaluations, training professionals and on the website.
_____ I CONSENT _____ I DO NOT CONSENT

RESTRICTIVE PROCEDURE CONSENT Thrive Behavioral Consultants may need to implement restrictive procedures as a safety precaution. These procedures are based on the behavioral safety program in the event of a crisis or if de-escalation of problem behavior is required.

PATIENT NAME _____ **DOB** _____

PARENT/GUARDIAN _____ **SIGNATURE** _____

TBC THERAPIST _____ **DATE** _____

Thrive Behavioral Consultants
Greenville, SC

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal healthcare information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health providers to obtain their patient's consent for users and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to information to only those we feel are in need of your healthcare information about treatment, payment or healthcare operations, in order to provide health care that is in your best interest.

We also want you to know that we support you full access to your personal medical records. We may have indirect treatment relationships with you (such as physicians, nurses or other therapists that only interact with BCBA and no patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities most often require to Thrive Behavioral Consultants to obtain your consent.

It is our office policy not to release confidential information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (when you bring a friend or family member with you for your therapy, we will assume, unless you object, that that person is entitled to receive information regarding your treatment). (iv) in emergency situations or (v) as permitted by HIPAA Act of 1996.

By signing below, you authorize the release of medical information, appointments, medical records and/or claims information to the person below:

Authorized Individual _____ **Relationship** _____

You may refuse to consent the use of disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you chose to refuse to disclosed your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name _____ **Signature** _____ **Date** _____

Thrive Behavioral Consultants
Greenville, SC

Patient Privacy Compliance Assurance Notification

To Our Valued Patients:

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The Terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

Protected Health Information may be disclosed or used for treatment payment or healthcare operations, or for other purposes permitted or required by law. However, we will obtain from you a separate written authorization for "subsidized" (marketing or fundraising) disclosures, meaning disclosures involving product or services with respect to which the Consultants receives remuneration from a third party. Our practice does not participate with any "subsidized" disclosures; however, if we decide to give you the option to opt out according to HIPAA guidelines.

We also know that we are not perfect! Because of this fact, our policy is to listen to our therapists and patients without any thought of penalization if they feel that an event in any way compromised our policy of integrity. More so, we welcome your input regarding any problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Print Patient Name _____

Guardian Signature _____ **Date** _____