ExpertCare

Therapy Services

Recipient Information Form

Recipient Name: _____

Address: _____

Date of Birth: _____ **Diagnosis:** _____

Guardian Information:

Primary Parent/Guardian Name: _____

Home Phone: _____ Cell Phone: _____

Email address: _____

Secondary Parent/Guardian Name: _____

Home Phone: _____ Cell Phone: _____

Email address: _____

Guardian's Address, City, State & Zip: (if different than recipient's address):

_____

Emergency Contact (other than parent/guardian listed above):

Name of Person to contact in case of emergency: _____

Relationship to Recipient: _____

Contact's Phone Number: _____

Recipient's interests/likes/dislikes:

Additional Information about the recipient you'd like us to know:

Do you have any pets in the home?
___ Yes
___ No

**If yes, what kind of pets and how many?*

_____

Does anyone in the home smoke?
___ Yes
___ No

Where should staff park?

_____

Therapy Services Authorized Signature(s) For Timesheets

Recipient name: _____

Please fill out box(es) with Parent or Guardian's information and signature(s). Only legal guardian(s) information should be printed/signed in the box(es). Proof of guardianship documentation may be requested.

Parent/Guardian Name: (Please Print)
Phone Number:
Parent/Guardian Signature:
Type of Guardianship, if applicable:
Parent/Guardian Name: (Please Print)
Phone Number:
Parent/Guardian Signature:
Type of Guardianship, if applicable:

If someone other than a parent will be with recipient during therapy, please list their information below. We must have their actual signature, they will be signing timesheets verifying delivery of services. You must also add this individual to the Authorization to Disclose form.

1) Authorized Signer's Name: (please print)_____
Phone Number: _____ Relationship to Recipient: _____
Authorized Signer's Signature:

2) Authorized Signer's Name: (please print) _____
Phone Number: _____ Relationship to Recipient: _____
Authorized Signer's Signature:

I understand that an adult must accompany the recipient and remain in the building while the recipient is receiving therapy services.

Parent/Guardian Signature:

Printed Name of person signing:

ExpertCare

Authorization to Disclose Protected Health Information

Recipient's Name: _____ **Recipient's Date of Birth:** _____

Street Address: _____

Phone Number: _____

Email Address: _____

I authorize ExpertCare to disclose the above-mentioned individual's health and billing information as described below. This can be used for coordination of benefits billing. (Identify type and amount of information, including dates where appropriate.) (example: all therapy services or treatment plans)

**Please Note: ExpertCare must have authorization prior to communicating with your Primary Care or referring physician regarding services. Please list your physician contact information here:*

Primary Care or Referring Physician Name: _____

Office Address: _____

Phone Number: _____ Fax Number: _____

The above information may also be disclosed to and used by the following persons or organizations: **If you have listed any individuals on the Authorized Signer form other than parent/guardian, please list all individuals in this section.*

Name of Person/Organization: _____

Relationship to recipient: _____

Phone Number: _____

Name of Person/Organization: _____

Relationship to recipient: _____

Phone Number: _____

This disclosure and use is for the following purpose(s):*

**Note: The statement "at the request of the individual" is sufficient when the individual initiates an Authorization and does not, or chooses not to, state the purpose.*

I understand that if I give permission, I have the right to change my mind and revoke it. This must be in writing to ExpertCare. I also understand that any uses or disclosures already made with my permission cannot be taken back.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition. **(If I fail to specify an expiration date, event or condition, this authorization will expire one year from the signature date.)**

_____

Date, Event or Condition

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain services.

By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed Authorization.

I authorize ExpertCare to provide communication regarding services through the following: (please check all that apply)

- **Text messages**
- **Voicemail messages to my home and/or mobile phone**
- **Email messages**

Parent/Guardian or Legal Representative's Name (if applicable)	**Relationship to the Individual receiving services** (A letter of authority may be requested)
Signature of Parent/Guardian or Legal Representative	**Date**

Recipient Name: _____

Recipient Rights Policy Acknowledgement

Please review our Recipient Rights Policies and sign below.

I ACKNOWLEDGE THAT I HAVE RECEIVED AND REVIEWED THE EXPERTCARE MANAGEMENT SERVICES RECIPIENT RIGHTS POLICIES AND HAVE BEEN PROVIDED AN ELECTRONIC COPY OF THEM.

_____

Recipient or Legal Representative Signature **Date**

Privacy Notice Acknowledgement

Please review our Privacy Notice. Please sign below. Our Privacy Practices are for your protected health information.

I ACKNOWLEDGE THAT I HAVE REVIEWED THE EXPERTCARE MANAGEMENT SERVICES NOTICE OF PRIVACY PRACTICES AND HAVE BEEN PROVIDED AN ELECTRONIC COPY OF THE NOTICE. I ACKNOWLEDGE THAT I MAY REQUEST A COPY OR ACCESS THESE POLICIES ON THE EXPERTCARE WEBSITE.

_____

Recipient or Legal Representative Signature **Date**

CONSENT TO TREAT

RECIPIENT NAME: _____ **DATE OF BIRTH:** _____

CONSENT TO TREAT: The undersigned, whether signing as the recipient of services or the authorized representative, hereby, give permission for authorized contractors and employees of ExpertCare Management Services ("Agency") to perform all necessary procedures and treatments outlined in my Individual Plan of Service/Person Centered Plan, signed by me or my representative via telehealth. I understand that all procedures and treatments must be ordered by my physician. I understand that I have been fully informed of the anticipated benefits, possible discomforts, and potential side effects prior to the performance of any medical treatment.

RECIPIENT RESPONSIBILITIES

As a recipient of services from of our Agency, you have the responsibility to:

1. Provide an accurate medical history, communicate any changes in your health status, complications, or side effects of prescribed treatment.
2. Have a physician and remain under medical supervision while receiving services from ExpertCare.
3. Follow an established medical emergency plan.
4. Treat Agency personnel with dignity, courtesy and respect.
5. Notify Agency personnel of the desire to change or cancel any service and/or treatment with proper notice & notify the Agency if you will not be available for a scheduled visit.
6. Provide accurate insurance and/or financial information and to notify ExpertCare of any changes in your insurance coverage.
7. Maintain a private environment for services to be completed via telehealth with an adult present during all treatment sessions.
8. Telehealth therapy sessions & evaluations must be completed utilizing audio & video methods on a non-public platform. Ex: Zoom, Teams, Google Meet, FaceTime, Skype etc. (Not acceptable are TikTok, Facebook Live, SnapChat, Instagram live, etc.).

CUSTOMER SERVICE/GRIEVANCE PROCEDURE:

You have been provided or directed where to obtain a copy of the Office of Recipient Rights Complaint Form and Your Rights Booklet. If you wish to voice a concern regarding your care or recommend changes, please follow the steps outlined below:

1. Notify your ExpertCare Management Services Representative at 248-643-8900.
2. You may also speak with the clinician that provides services or the Therapy Manager at 248-643-8900.
3. Contact your Case Manager at your Provider Agency or the Office of Recipient Rights.

RECIPIENT RIGHTS

My rights and responsibilities have been explained, and I have received a copy of and had my questions answered regarding:

- ✓ My Rights and Responsibilities; including access to the Recipient Rights Handbook
- ✓ The Agency's Notice of Privacy Practices
- ✓ The procedure to voice grievances and recommend changes in policies/service - I understand that this mechanism may be accessed without fear of coercion, discrimination, reprisal or unreasonable interruption of services.

I, the undersigned, have read, understand and agree with the above information. I agree to receive services provided to me by ExpertCare Management Services, as authorized by the mental health authority that I am affiliated. I am aggreging to telehealth services provided via audio & video methods or phone call as needed to continue the services for my loved one.

RECIPIENT OR REPRESENTATIVE SIGNATURE:_____ DATE: _____

PRINTED NAME OF PERSON SIGNING: _____

Relationship to Recipient: _____

Speech Language, Physical & Occupational Therapy Agreement

Recipient Name: _____

Based upon the evaluation and recommendation of the therapist, I agree that my loved one can benefit from therapy services. I understand that consent to be part of this program, I agree to the adhere to the following:

- Schedule compliance- It is important for your loved one's success that they are home to participate in therapy appointments as indicated in the therapy Plan of Care. The appointments will be scheduled weekly at the same day and time. **It is our expectation that when you agree to a weekly appointment time for therapy services, that other appointments are scheduled at different times to allow consistency in treatment.** If you must cancel for any reason, you must call the ExpertCare therapy department at 248-643-8900 prior to your scheduled appointment.
- Attendance- To attain maximum benefit, **we request 75% attendance rate for scheduled appointment throughout the year**. We understand that there are times you must cancel your appointments. If cancellations exceed more than one time per month, you may be placed on the wait list for other days. If your current schedule no longer works for you, please call the office to discuss alternate times/days. If you must cancel an appointment, call 248-643-8900 prior to the appointment time.
- Supervision- An adult must be present in the home while the recipient is receiving services. ExpertCare cannot be responsible for your loved one once a therapy session has ended. If an adult other than the parent/guardian is present during therapy, you must add that individual's name to the *'Authorization to Disclose Protected Health Information'* form AND the '*Authorized Signer'* form. **Please note, CLS and Respite staff cannot provide services while a therapist is working with the client.**
- Family Responsibilities- While receiving ExpertCare services, therapists, office staff, and the family will work as a team. **It is the family's responsibility to engage in open communication with ExpertCare to ensure the best quality services for your loved one**. Parents may be asked to participate in therapy sessions; participation may increase the probability of progress toward the identified goals. Therapists may also provide at-home work to enhance understanding and implementation of therapy techniques.

- I acknowledge that ExpertCare therapy services have been explained to me.
- I agree to work in collaboration to promote my child's progress toward their goals indicated in the Individual Plan of Service/Person Centered Plan.
- I understand that if I have any questions or concerns regarding my rights, responsibilities, or preferences, I may contact the ExpertCare office at 248-643-8900.

Parent/Guardian Signature: _____ Date:_____

Printed Name of Signer: _____

APPOINTMENT CANCELLATION POLICY

Recipient Name: _____

You must notify the ExpertCare office if you need to change or cancel an appointment.

DO NOT call the clinician that provides therapy services to your loved one.

24-hour notice is required to cancel a scheduled visit.

If you encounter unforeseen circumstances that do not allow you to keep your scheduled appointment, call ExpertCare immediately at **248-643-8900.**

No-Call, No-Show Policy:

If our clinician arrives at your home for a scheduled appointment and there is no one at home, the following procedures will be followed:

a) The clinician will return to his/her vehicle and call the ExpertCare office. The office staff will call all recipient contact numbers on file. If the recipient will be returning home within 10 minutes of the scheduled appointment, the clinician will wait for the recipient to arrive. The clinician will conduct the therapy services; however, the session may be shortened to allow the clinician to remain on schedule for other recipients. If the recipient will be unable to return to the home within 10 minutes of the scheduled appointment, or there is no answer from the telephone inquiries; the clinician will leave the home. This will be considered a **"NO CALL NO SHOW" appointment.**

b) The second occurrence of a "NO CALL NO SHOW" appointment will result in a letter sent to the family and the Supports Coordinator. This letter will state the recipient MAY be at risk of discharge from ExpertCare due to two instances of "NO CALL NO SHOW" appointments within the last year and non-compliance of the Plan of Care. An alternate schedule may be discussed, or the recipient may choose to seek alternate therapy providers. ExpertCare will continue to provide in-home services with the agreement that the recipient/family will adhere to the ExpertCare cancellation procedure.

c) The third occurrence of a "NO CALL NO SHOW" appointment, will result in ExpertCare initiating notice of termination of therapy and/or any skilled services being provided. ExpertCare will continue to provide therapy services for 7-days following the date of notification. At the end of the 7-day period, ExpertCare will discontinue therapy services to the recipient. If a new therapy provider is selected prior to the discharge date, ExpertCare will end services at that time. If the recipient has a NO CALL NO SHOW during the 7-day discharge period, that will signify the recipient wishes to terminate services immediately and forfeit the 7-day discharge period.

ExpertCare understands circumstances do come up and each situation will be looked at individually. If you need to cancel you MUST NOTIFY ExpertCare to not receive a "NO CALL NO SHOW." When there is a lack of communication regarding the cancellation, a "NO CALL NO SHOW" will be issued.

Signature of Authorized Representative: _____

Printed Name: _____ Date: _____

MEDICAL HISTORY FORM

Recipient Name: _____

	Y	N		Y	N
ALLERGIES (SEASONAL)			DIABETES MELLITUS		
ADD/ADHD			ECZEMA/DERMATITIS		
ANEMIA			GLAUCOMA		
ANXIETY			HEADACHES/MIGRAINES		
ASTHMA			HEART ATTACK		
ARTHRITIS			HEARTBURN (ACID REFLUX)		
CATARACTS			HEART DISEASE (CLOGGED ARTERIES)		
CANCER: TYPE:			HEART MURMUR		
CHRONIC ABDOMINAL PAIN			HIGH BLOOD PRESSURE		
CHRONIC CONSTIPATION			HIGH CHOLESTEROL		
CHRONIC DIARRHEA			IRREGULAR MENSTRATION		
CHRONIC EAR INFECTION			KIDNEY PROBLEMS		
CHRONIC VOMITING			LIVER PROBLEMS		
CHRONIC NAUSEA			SEIZURES		
CONGESTIVE HEART FAILURE			STROKE		
COPD/EMPHYSEMA			THYROID PROBLEMS (OVER OF UNDER ACTIVE)		
DEPRESSION					

OTHER CONDITIONS NOT LISTED ABOVE:

SURGICAL HISTORY (list only those in the previous 12 months)

ALLERGIES:

_____

MEDICATIONS

Please include over-the-counter medications, vitamins & herbal supplements. **You may include a printed list if you have one. Please use the back of this form if you need more room.**

MEDICATION NAME	DOSE	TIMES TAKEN PER DAY

SOCIAL HISTORY

DOES THE RECIPIENT SMOKE? __YES __NO

DOES THE RECIPIENT DRINK ALCOHOL? __YES __NO

DOES THE RECIPIENT DRINK CAFFEINE? __YES __NO

PRINTED NAME OF PERSON COMPLETING FORM (if not recipient):

_____

SIGNATURE OF PERSON COMPLETING FORM:

_____

DATE: