SERVICE AGREEMENT

Client Full Name: _____ Date of Birth: _____

Introduction

Welcome to Diverge Community Services, LLC! We thank you for choosing our occupational therapy services and for investing in your own path in life. You are worth it. This agreement is made between Diverge Community Services, LLC and the above-listed client. Please review carefully and inquire about any questions or concerns. Company Overview Through implementing evidence-based, strengths-first, and person-centered treatment, we support our clients in maximizing their independence and quality of life in the community. We strive to support our clients in embracing their own life paths while equipping them with the skills to use their strengths to their full potential and advocate for their needs. At Diverge Community Services, LLC, we provide three primary service categories: Occupational Therapy, Consultation, and Coaching. Your therapist will recommend which service type is best for you following your initial phone consultation.

Occupational Therapy

Occupational therapy evaluations and interventions address daily living skills including, but not limited to: executive functions, self-care, health management, medication management, home management, financial management, work, education, social interaction, emotional regulation, sensory processing, and motor skills. Evaluations assess an individual's skill level as it relates to everyday functioning. Based on evaluations, in collaboration with the client and other relevant providers, individualized goals are established to target concern areas. Intervention strategies include occupational therapy treatment in the client's home, at local community locations, or online via telehealth. Location of services is determined and adapted as needed in collaboration with the client. A client's progress is routinely monitored, and treatment plan modifications are made as needed. May be covered by insurance.

Consultation
Consultation services aim to address the fit between individuals, their environment, and their activities/responsibilities to promote inclusion, satisfaction, wellness, and efficiency. Consultation services differ from traditional occupational therapy services in one of three primary ways:
1. No formal evaluation or treatment plan; services occur as needed
2. The consumer is typically a group or organization, though may an individual or loved one
3. Address more targeted needs, versus general functioning
Not covered by insurance.

Coaching
With coaching services, we engage clients in thought-provoking and creative processes that inspire them to maximize their personal and professional potential. This service aims less at skill building and more at maximizing and unleashing what is already there while developing collaborative action plans and recruiting strategies and systems that work. Effective coaching requires a high level of self-awareness and a desire for self-improvement. Not covered by insurance.

Location Settings
Services may be provided in the client's home, the community, and over telehealth. Location is subject to approval by the provider.

- *Rachel Robertson,* OTRL provides services in the Washtenaw County Area within 25 miles of her home free of charge. Services outside this 25-mile radius are available at an additional per-mile charge. Rachel is licensed in Michigan and Florida for telehealth services.
- *Stephanie Olszewski,* OTRL provides services in the Wayne County Area within 25 miles of her home free of charge. Services outside this 25-mile radius are available at an additional per-mile charge. Stephanie is licensed in Michigan, Illinois, and Florida for telehealth services.

Attendance Policy
Cancellation: We know how precious time is, so we ask that a 24-hour notice is provided for appointment cancellation. This allows us the opportunity to provide valuable services to others at that time. If less than 24 hours but more than 1-hour notice is provided, you will be charged 50% of your total service fee. If you miss your appointment without notice or provide notice within the hour preceding your session time, you will be charged the full amount of your service.
Tardiness: You will be charged the typical service rate for tardiness. Chronic tardiness (> 10-minutes) may alter your services' effectiveness and make you subject to service termination.

Nature of The Therapeutic Relationship
At Diverge Community Services, LLC we believe the therapeutic rapport is the backbone of effective treatment. Similarly, we value compassion and collaboration in all therapeutic encounters. However, we believe that setting clear professional boundaries from day one is necessary for the effectiveness and safety of this therapeutic alliance. All therapeutic relationships will be professional in nature, mutually respectful, non-romantic, and non-exploitative. Providers will refrain from participating in unrelated social or nontherapeutic contact outside of sessions.

Practice Standards
Diverge Community Services, LLC operates with guidance from the Occupational Therapy Practice Framework: Domain and Process 4th Edition published by the American Occupational Therapy Association (AOTA, 2020), which outlines foundational principles of occupational therapy as a profession and promotes best practice. Our providers also operate under the AOTA 2020 Occupational Therapy Code of Ethics, which outlines core values, ethical principles, and standards of conduct. Diverge Community Services, LLC providers are nationally registered with the NBCOT and licensed in the State of Michigan and strive to maintain practices utilizing current evidence-based research.
Non-Discrimination Statement Diverge Community Services, LLC does not and shall not discriminate based on race, national origin, religion, color, sex, gender, ability, age, ethnicity, sexual orientation, marital status, or military status in any activities or operations. We are committed to providing an inclusive and welcoming environment for all clients, staff, health partners, and community partners.

Non-Discrimination
Statement Diverge Community Services, LLC does not and shall not discriminate based on race, national origin, religion, color, sex, gender, ability, age, ethnicity, sexual orientation, marital status, or military status in any activities or operations. We are committed to providing an inclusive and welcoming environment for all clients, staff, health partners, and community partners.

By signing below I agree I have read, understood, had the opportunity to clarify any questions, and agree to the above information.

Client/Guardian Signature: _____

Today's Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your healthcare is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you and describe certain obligations I have regarding the use and disclosure of your health information.
I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules and regulations allow healthcare providers who have direct treatment relationship with the client to use or disclose the client's personal health information without the client's written authorization, to carry out the healthcare provider's own treatment, payment or healthcare operations. I may also disclose your protected health information for the treatment activities of any healthcare provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed healthcare provider about your condition, we would be permitted to use and

disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your condition. Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other healthcare providers need access to the full record and/or full and complete information in order to provide quality care. The word “treatment” includes, among other things, the coordination and management of healthcare providers with a third party, consultations between healthcare providers, and referrals of a patient for health care from one healthcare provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Treatment Notes. I do keep "treatment notes" and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
    a. For my use in treating you.
    b. For my use in training or supervising occupational therapy practitioners to help them improve their skills in therapy.
    c. For my use in defending myself in legal proceedings instituted by you.
    d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
    e. Required by law and the use or disclosure is limited to the requirements of such law.
    f. Required by a coroner who is performing duties authorized by law.
    g. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION:

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone’s health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the outcomes of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other healthcare services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT:

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or healthcare operations purposes. I am not required to agree to your request, and I may say “no” if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or healthcare operations purposes if the PHI pertains solely to a healthcare item or a healthcare service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. You have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost-based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or healthcare operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right to get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

VII. USE OF NON-ENCRYPTED COMMUNICATIONS:
We do not have a BBA with gmail or our phone provider so any communications through gmail, text, or phone call will not be encrypted.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE:
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing this document, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices. I certify that I have received, read, and understood the entire contents of Diverge Community Services, LLC's Notice of Privacy Practices and have had sufficient opportunity to ask questions. I understand that I may contact my therapist at divergecs@gmail.com or 734-707-7219 with any questions, comments, or concerns.

Client/Guardian/Cardholder Signature: _____

Today's Date: _____

DIVERGE
Community Services llc

INFORMED CONSENT TO OCCUPATIONAL THERAPY TREATMENT

Provided by Rachel Robertson, MOT, OTR/L, Certified Brain Injury Specialist; Co-Founder

Client Full Name: _____ Date of Birth: _____

By signing this document, I am agreeing to the following:

- I authorize the above-named occupational therapist to evaluate and treat as deemed appropriate through the use of occupational therapy measures and I authorize these procedures to be performed.
- I acknowledge that I am given the opportunity to discuss the treatment recommendations, the risks and potential complications of treatment, and explore alternative methods of treatment.
- I understand that I retain the right to refuse any particular evaluation, procedure, or treatment that is recommended.
- I agree that I will ask questions if I have them before consenting to any treatment.
- I understand that the occupational therapist is not liable for accidents and/or injuries caused to me except in the case of negligence.
- I understand that the occupational therapist is not responsible for any personal items or valuables that I use or are present in our sessions.
- I understand that some treatment may involve risk of injury and adverse results.
- I acknowledge that no guarantees have been made to me as to the results of treatments that I may undergo while receiving therapy services from the occupational therapist.

Client/Guardian Signature: _____

Today's Date: _____

INFORMED CONSENT FOR TELEHEALTH TREATMENT

Client Full Name: _____ Date of Birth: _____

About

Telehealth is live two-way audio and video or audio-only electronic communications that allows therapists and clients to meet outside of a physical in-home or community setting. This option is made available to provide increased access to services.

Client Understanding

- I understand that telehealth services are completely voluntary and that I can withdraw this consent at any time.
- I understand that none of the telehealth sessions will be recorded or photographed. I agree not to make or allow audio or video recordings of any portion of the sessions.
- I understand that the laws that protect privacy and the confidentiality of client information also apply to telehealth and that no information obtained in the use of telehealth that identifies me will be disclosed to other entities without my consent.
- I understand that audio-video telehealth is performed over a secure video communication system that is almost impossible for anyone else to access. I understand that any internet-based communication is not 100 % guaranteed to be secure. I understand that phone-based telehealth is completed outside of the secured system above and is not guaranteed to be a secure method of communication.
- I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.
- I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.
- I understand that I or my therapist may discontinue the telehealth sessions at any time if it is felt that the video technology is not adequate for the situation.
- I understand that if there is an emergency during a telehealth session, then my therapist may call emergency services and/ or my emergency contact.
- I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to telehealth services.

- I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for re-contact.
- I understand the same cancellation and tardiness policies apply to telehealth and in-person services. A “no show” or late fee of 50% total appointment fee will be charged if I miss an appointment or do not cancel within 24 hours of scheduled appointment. I understand credit card or another form of payment will be established before the first session.
- I understand my therapist will advise me about what telehealth platform to use and she will establish a video conference session.

I hereby give my informed consent for the use of telehealth in my care.

Client/Guardian Signature: _____

Today's Date: _____

DIVERGE
Community Services llc

PAYMENT POLICY

Payment Methods Accepted

Cash (in exact change), Check, Credit, Debit, and some insurances. Visa, MasterCard, American Express, Discover, Diner's Club, and JCB are accepted. A 3% transaction fee will be applied for any payments made with credit or debit card.

Regarding Insurance

We currently accept Auto No-Fault for conditions resulting from a motor vehicle accident in the state of Michigan. We are happy to submit the claims necessary to see that you receive your benefits. The insurance contract is an agreement between you and the insurance company. You are ultimately responsible for all charges. We cannot guarantee that any coverage estimated by your plan will be paid once a claim is filed. For all other insured individuals, you may request and submit a Superbill. Superbills, detailed invoices to submit to insurance for reimbursement, may be provided by the treating provider at time of service. Be sure to check with your insurance prior to submitting a superbill to receive prior authorization for your out-of-network services. Coverage is not guaranteed, and the client is financially responsible for services at service rendering.

Late and Cancellation Fees

We know how precious time is, so we ask that a 24-hour notice is provided for appointment cancellation. This allows us the opportunity to provide valuable services to others at that time.

- If less than 24 hours but more than 1-hour notice is provided, you will be charged 50% of your total service fee.
- If you miss your appointment without notice or provide notice within the hour preceding your session time, you will be charged the full amount of your service.

Please bear in mind that insurance will not cover the cost of late and cancellation fees.

Timeliness of Payment

Payment is due at the time of service rendering. Any outstanding payment is subject to a late fee. Any outstanding debt 30-days past the date of rendering is subject to be reported to collections.

Private Pay Service Rates
Occupational Therapy Hourly Treatment: $25/15-minute; $100/hour
Initial Evaluation: $175/hour
Reassessment: $150/hour Any client-initiated phone calls and texts exceeding 15-minutes will be charged at $25/15-minute

Travel Fees (One-way)
The first 25 miles are free. Each mile after the initial 25 is charged at $2.00/mile. We only charge one way :) The travel route is determined using the shortest trip (mileage) via Apple Maps.

Agreement
I understand that service rates are subject to regular review and may be modified in relation to changing market conditions. You are entitled to timely notice of such changes.

I should contact my therapist at divergecs@gmail.com or 734-707-7219 for any questions or clarification of this policy.

By signing below, I certify that I have received, read, understood, and agreed to the entire contents of this Payment Policy, and I have had sufficient opportunity to ask and clarify questions.

Client/Guardian Signature: _____

Today's Date: _____

DIVERGE
Community Services llc

CREDIT/DEBIT PAYMENT CONSENT

Client Name: _____
Name on card if different than client: _____
Card Type: _____
Last 4 digits of card number: _____
Expiration Date: ___/____

Authorization

- I authorize Diverge Community Services, LLC to charge my credit/debit card for professional services at the time of appointment. I understand I will be charged a 3% processing fee for credit/debit card transactions that is waived when paying with cash or check.
- I understand that if I have elected to bill my auto insurance, my credit/debit card will only be billed in instances of cancellations, as denoted below, or for additional services not covered by insurance after I have provided informed consent for these services.
- I understand that if I do not show up for my appointment without notice (no-call-no-show) I will still be charged the full appointment amount. If I cancel within 24 hours of the appointment time, I recognize that I will be charged 50% of the total appointment fee for a late cancellation.
- I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Client/Guardian/Cardholder Signature: _____

Today's Date: _____

AUTO NO-FAULT INSURANCE DETAILS

Did your condition result from a motor vehicle accident?

- ☐ Yes
- ☐ No (if no, skip this form)

If yes, name of Auto Insurance Provider:_____

Date of Injury: _____

Name of Insured: _____

Adjuster Name: _____

Claim Number:_____

Prescribing Physician: _____

Physician Phone Number: _____

Physician Fax Number:_____

DIVERGE COMMUNITY SERVICES, LLC
RELEASE OF INFORMATION

Client Full Name: _____ **Date of Birth:** _____

I authorize Diverge Community Services, LLC to share my health information:
List the amount and type of information you would like to share in the section below. For example, you can say all my health information or list certain types of information you'd like to share.

_____

_____

_____

___

Diverge Community Services, LLC may share my health information with the following person or organization:
Name of person/organization*: _____

Address: _____

Phone Number: _____Fax: _____

Email: _____

Diverge Community Services, LLC may share my health information for the following reason: *For example, to discuss my health care at the request of the individual.*

_____

_____

_____

___

Diverge Community Services, LLC uses My Clients Plus, a Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant software, for patient communication and telehealth sessions. Please check additional types of communication that you consent providers to utilize:

- ☐ Phone
- ☐ Text (not encrypted)

☐ Email (not encrypted)

☐ Mail

By signing this form, I understand that:

- I do not have to sign this authorization.
- My refusal to sign this authorization will not affect my ability to obtain treatment, payment for services, enrollment or eligibility for benefits.
- Information regarding behavioral and mental health services, substance use disorder treatments, and communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related complex) may be shared if I initial here or if I list this type of information above _____.
- If I authorize the release of substance use disorder treatment information, the recipient cannot re-disclose this information without my permission unless permitted under federal or state law.
- Other types of information shared under this authorization may be re-disclosed by the person or organization I identified above and may no longer be protected by federal or state law.
- I may change my mind and revoke (take back) this authorization at any time. To revoke this authorization, write to divergecs@gmail.com.
- Information that has already been shared based on this authorization cannot be taken back.
- I may request a copy of this signed authorization.
- If I have not previously revoked this authorization, it will expire on: _____ *(If you leave blank, the authorization will expire one year from the signature date)*

I understand that uses and disclosures for reasons other than treatment, payment, or operations may be permitted without prior consent in a medical emergency.

I understand that this document will remain valid for 1 year after the date of my signing unless a new version is signed within a year.

I certify that I have received, read, understood, and agreed to the entire contents of this Release of Information and have had sufficient opportunity to ask questions.

Client/Guardian Signature: _____

Today's Date: _____

AUTHORITY: This form is acceptable to the Michigan Department of Health and Human Services as compliant with HIPAA privacy regulations, 45CFR Parts 160 and 164 as modified August 14, 2002