Southland Therapy Services, Inc.

PH(912) 335-1650 FAX(912) 335-2377

Patient Information and Therapy Authorization

Male

Female

Patient Name:____________________Date of Birth:________________Age:________

Address:________________________City:________________State:______Zip:________

Pediatrician:_____________________Pediatrician Phone#:________________

Phone:(home)________________(work)____________(cell)____________(other)____________

Caregivers Name (and relationship)____

Email address ____

Does patient have an IEP(Individual Education Plan) or IFSP(Individual Family Service Plan)? YES NO

IF YES PLEASE BRING A COPY WITH YOU AT YOUR NEXT APPOINTMENT.

Primary Insurance Coverage Information

Payor:____________________Plan____________Policy#______________Group#__________

Claims address:______________________________________Phone:____________________

Policy Holder Information:

Full Name:__________________________Relationship to patient:__________DOB:__________

Employer:___________________________Gender:______________

Address and Phone # (if different than Patient)____

Secondary Insurance Coverage Information

Payor:____________________Plan____________Policy#______________Group#__________

Claims address:______________________________________Phone:____________________

Policy Holder Information:

Full Name:__________________________Relationship to patient:__________DOB:__________

Employer:___________________________Gender:______________

Address and Phone # (if different than Patient)____

Patient Financial Responsibility (please initial each):

______ I understand that I have been referred for therapy services and care with Southland Therapy Services. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have Southland Therapy Services provide treatment and care as prescribed by my physician and/or recommended by my therapist.

_______ I hereby authorize Southland Therapy Services to furnish my insurance company(s) any information that may be required in order to determine benefits and process claims. I authorize payment of medical benefits to Southland Therapy Services for services rendered to me. I certify by my initials that I have read the above and agree to this policy.

_______ **Any services rendered are charged to the patient and due at the time of service.** As a courtesy Southland Therapy will file your claim with your insurance carrier, however the patient or responsible party is ultimately responsible for the charges not covered by your insurance. Any copayments or deductible amounts not satisfied with your carrier are due at the time of service. It is the patient's responsibility to understand their insurance coverage.

_______ Statements from Southland Therapy Services are due upon receipt. I acknowledge that I am financially responsible to Southland Therapy for any balance not covered under my plan from my insurance carrier. If a discrepancy exist with your balance due, please contact Southland Therapy otherwise your payment is expected upon receipt. Unpaid balances can ultimately result in accelerated collection practices.

_______ I am aware that Southland Therapy **reserves the right to charge a fee of $25.00 for missed unexcused absences and for arriving 10 or more minutes late.**

Patient Name:____

Patient/ Authorized Representative (Parent) signature:______________________________Date______________

Southland Therapy Services, Inc. (STS)
Phone: 912.335.1650
Fax: 912.335.2377

Company Policy/ Cancellation/ Sick/ Rx

Please initial each line:

_______ I understand that if my child becomes ill I should cancel therapy until my childhas remained fever-free (without pain relievers) and/or symptom free for at least 24 hours. Symptoms include: diarrhea, throwing up, rashes, strep throat (must be on antibiotics for at least 24 hours), and severe cold / flu symptoms as determined.

_______ I understand that if I must cancel a therapy session, I should call my therapist at least 24 hours before the session. The therapist will provide me with her contact number or you may call the office at 912.335.1650 to cancel.

_______ I understand that Southland Therapy Services, Inc.(STS) may discontinue services when 2 sessions are missed without prior notification. (No Shows)

_______ I understand that excessive cancellations will also provide STS inc. reason for discontinuing services. This will be determined at the discretion of the owner of the company.

_______ I understand that STS will try to reschedule any therapy sessions that are cancelled by either the patient or the therapist.

_______ It is the parent/ caregivers responsibility to remain current with well visits to the primary care physician(PCP). Should your Rx for therapy expire, STS will contact your PCP for an updated Rx. **HOWEVER** if the physician will not write a new therapy prescription without the patient attending a well visit appointment, **STS is REQUIRED to place your child on HOLD and discontinue services until an updated Rx is obtained.**

Patient Name:____

Parent or Legal Guardian's Signature:_____________________________________

Date: ________________________________

1/2013

Southland Therapy Services, Inc.
PO Box 30606
Savannah, GA 31410
Phone: (912) 335-1650

Consent to Release and/or Obtain Information

Patient Name: ____ **Date of Birth**:____________

Parent / Guardian Name: _______________________________

My signature on this form indicates that I (parent or legal representative)

- Authorize the contracted therapists and company representatives to disclose and / or obtain specific health / medical and educational information from the records of the above named child
- Understand that I may request a copy of any information that is disclosed or obtained
- Agree that a copy of this consent may be treated as an original
- Understand that if the record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, or genetic testing this disclosure may include that information
- Understand that this information may be released in any of the following ways: fax, email, direct mail, wireless communication or by telephone
- Understand that, while services will not be denied because of failure to sign this consent form, inability to collect necessary information may cause denial of eligibility for Therapy Services with Southland Therapy Services, Inc.
- Grant consent from the date I sign the consent until discharge of the patient from Southland Therapy Services, Inc.
- I authorize Southland Therapy Services, Inc. to use and/or disclose my protected health information to physicians, payers of health care services and other heath care providers to help provide appropriate treatment for my child.

___________________________________ ____________________

Parent or Legal Representative Signature **Date**

NOTICE OF PRIVACY PRACTICES

By law, we are required to provide you with our **Notice of Privacy Practices (NPP)**. This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.
As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this notice should you desire.

We want to assure you that your medical / protected health information is secure with us. This Notice contains information about how we will insure that your information remains private. If you have any questions about this notice, contact the name as listed and the phone number on this page: Dawn Kearney

Acknowledgement of Notice of Privacy Practices

“This acknowledges that I have received a copy of this practice’s **Notice of Privacy Practices**. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer the updates to this **Notice of Privacy Practices** should it be amended.

Patient Name:____ **Date**:________________________

Parent or Legal Representative Signature:____

Southland Pediatric Therapy, Inc.

Patient Service Agreement

(please initial each line to show you agree)

Patient Name:____

______ It is the patient/parents(s)/guardian responsibility to inform Southland Pediatric Therapy, Inc. (STS) of any and all changes in insurance information, including group policy number, identification number, phone numbers, addresses, etc. as soon as possible. **Failure to do this could result in total patient responsibility for charges incurred.**

______Southland Pediatric Therapy, Inc. realizes the parent/legal guardian or caregiver's time is important, and it is our sincere intention to honor all appointment times. On occasion, a delay or emergency will occur. For this reason, we may need to delay or reschedule the patient's appointment. If this occurs, notification will be given as early as possible. To expedite this process, we ask the parent/legal guardian/caregiver to provide us with a daytime telephone number for notification purposes.

______**Cancellation Policy –** We are committed to providing quality consistent services to our clients. Therapy will be most beneficial to your child with **consistent attendance**. It is also important that you **arrive on time** so that your child can benefit from a full session. Please arrive on time for your therapy session. Patients arriving more than 10 minutes past the scheduled appointment time will be considered a no show and the appointment cancelled. Routine tardiness may result in billing that time directly to you. **In order for us to plan appropriately for staff, we require that parents call to cancel the appointment for illness or an unavoidable conflict as soon as possible.** **We reserve the right to charge a fee of $25.00 for missed unexcused absences and for arriving 10 or more minutes late.** Termination of services may occur following two sessions that were not cancelled ahead of time or following routine/regular cancellations. There are many families that are waiting for services. We appreciate your cooperation with this.

______For your convenience, Southland Pediatric Therapy, Inc. allows parents/legal guardians or caregiver to leave the premises during their child's appointment. However, it is very important to be back on the premises 15 minutes before the patient's appointment is scheduled to end so the therapist can discuss treatment with the parent/legal guardian or caregiver. If Southland Pediatric Therapy, Inc. notices chronic tardiness in picking up children, we will begin asking the parent/legal guardian or caregiver to stay during the patient's treatment. Southland Pediatric Therapy, Inc. must have a cell phone number to reach you before leaving.

______Information regarding child's therapy session may be discussed in the office waiting area with others present. You have the right at any time to request that this happen in a private room. This request must be made verbally to the therapist at the time of discussion.

______**Consent to release photo of your child and consent to video your child during a therapy session**: Therapists sometimes use photos/ videos to track the progress of the child's treatment program. Also includes possible display of a picture of your child (names will not be used without additional approval) in our brochure, website, advertisement/ promotional activity and/or in our clinic.

Parent/Legal Guardian's Signature ___________________________________**Date**____________________________

SOUTHLAND PEDIATRIC THERAPY
Patient Consent Form

DATE:_________________________

The therapists and staff of Southland Pediatric Therapy may discuss information pertaining to child/ children's therapy session with the following people on this list. **THE FOLLOWING PEOPLE HAVE MY PERMISSION TO BRING MY CHILDREN TO THERAPY IN CASE I AM UNABLE TO:**

Name: Relationship to child:

1. ____
2. ____
3. ____
4. ____

Patient name: Date of Birth:

1. ____
2. ____
3. ____
4. ____