THERAPY SPECIALISTS of Georgia

"Covering Everything Under the Umbrella"
4116 Arkwright Road, Macon GA 31210 O: 478-477-0601 F: 478-477-0133
Kay W. Hancock, Owner

PATIENT INFORMATION

Please provide: Copy of Insurance Card (front and back), copy of Driver's License, Social Security Number or Card

Patient Name:		
Address:		
Patient's DOB:	Sex:	Marital Status:
Parent/Guardian's Name:		
Person responsible for Payment:		
Driver's License Number:		
Parent/Guardian's Social Security Number:	Parent/Guardian's DOB:	
Parent/Guardian's Occupation/Employer:		
Patient's Name of School/Grade:		

Phone Numbers	
Parent/Guardian 1:	Parent/Guardian 2:
Home:	Home:
Work:	Work:
Cell:	Cell:

Primary Insurance:	**Secondary Insurance:**
Address:	Address:
Phone:	Phone:
Name of Insured:	Name of Insured:
DOB of Insured:	DOB of Insured:
Insured SSN:	Insured SSN:
Group #:	Group #:
Policy #:	Policy #:

I hereby authorize Therapy Specialists of Georgia, LLC to furnish information to insurance companies concerning my illness and treatments. I hereby assign Therapy Specialists of Georgia, LLC all payments for services rendered to my dependents and/or myself. I understand that I am personally responsible for any of service not covered by my insurance.

Signature of Responsible Party: _____ Date: _____

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EVALUATION/TREATMENT AUTHORIZATION

I, _____, authorize Therapy Specialists of Georgia, LLC to evaluate and/or provide therapy to _____.

I, _____, have been informed about the benefits _____ should receive from therapeutic intervention at this time.

All of my questions have been addressed. My insurance benefits for therapy have been explained to me. I am in full knowledge of coverage for therapy (including deductible, copayment, exclusions) and authorize evaluation and/or treatment for all disciplines (ST, OT, PT) pertinent to me.

Please note:

1. **If your insurance benefits have not been explained to you in detail, including any possible exclusions for therapy services, please ensure that you discuss this with the Office Manager. This is your right and responsibility.**
2. **For parents of minors: Parents must be present at the time of the initial evaluation.**

☐ I wish for my insurance company to be billed services. I hereby assign to Therapy Specialists of Georgia, LLC all payments for services rendered to my dependents and/or myself. I understand that I am personally responsible for any amount of service not covered by my insurance. I agree to pay any amount owed at the time of service (copay, deductible, etc.) and understand that services can be denied if I do not pay at the time of service. ___ (initial)

☐ I wish to self-pay for services. I agree to pay my bill at the time of service in full and understand that services can be denied if I do not pay at the time of service. ___ (initial)

Legal Guardian or Parent Signature Date

My signature below indicates that I verbally explained therapy (insurance) benefits to this patient, including information regarding deductible, copayment, exclusions regarding therapy services, etc.

Office Representative Date

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Patient Financial Responsibility

Payment is required at time of service. You are responsible for the full balance due if your insurance does not provide coverage for therapy or fails to pay the amount in full (within 90 days). You will be expected to pay your full balance before you receive additional services. If you are unable to pay your balance in full at the time of service, you will be turned away for services until your balance is paid in full. We cannot guarantee that a slot will be held for you while we are waiting on your payment.

However, you can always call back to be placed on the schedule once your balance is paid in full.
Verification of benefits is not a guarantee of payment. You are responsible for any charges not covered by your insurance. Benefits are subject to eligibility at the time of service. All specific plan provisions, exclusions and limitations will be applied at the time the claim is processed.
I understand I am responsible and will pay for all the following charges before my child or I attend the next therapy session:

CO-PAYMENTS/DEDUCTIBLE/CO-INSURANCE – due at time of service
LATE CANCELLATION (past 9:00 a.m. on day of service) without rescheduling a visit prior to next scheduled visit - $40
RETURNED CHECKS - $50/check
NO SHOW CHARGES – $50
OTHER FEES due after insurance processes - due upon receipt of invoice.

Please indicate your preference and sign below. (Check one only)
____ I agree to self-pay Therapy Specialists of Georgia for all services.
____ Therapy Specialists of Georgia should bill my insurance carrier and I will pay for co-payment, co-insurance, deductible and any other payment that my insurance does not cover that is related to billed amounts by Therapy Specialists of Georgia.
____ I will pay Therapy Specialists of Georgia for services rendered and Therapy Specialists of Georgia will provide me the information to bill my insurance carrier to attempt recoupment of funds.

I am fully aware that I am to pay my balance in full before the time of service and that if I cannot pay, I will be turned away for services until my balance is paid. I understand that I will be charged a late cancellation fee for cancelling past 9:00 on the day of service and I will be charged a no-show fee for not showing up for a scheduled appointment. I understand that I will be discharged from services for 2 no-shows and attendance that falls below 70%.

I, the undersigned, understand the above conditions to be a legally binding agreement.

_____ _____

Name / Relationship to Client Date

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I have read the attendance policies of Therapy Specialists of Georgia. I will make every effort to arrive on time for all appointments. I understand that attendance must remain at or above 75%. If I have to cancel my appointment, I will make every effort to reschedule my appointment. If I no-show, I will make every effort to reschedule the appointment. I understand there is a charge of $40 for late cancellations and a charge of $50 for no-shows.

_____

Signature of Patient or Guardian

_____

Patient Name

_____

Date

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RELEASE OF INFORMATION

I, (please print name) _____, authorize Therapy Specialists of Georgia to release and obtain clinical information regarding:

_____(Patient's Name)

_____ Medical Information – Diagnosis, Onset, Treatment Regimen
_____ School Documentation/IEP/FIE/Attendance
_____ Physician notes related to Speech/Language/Hearing/Cognition
_____ Psychiatric Evaluation/Treatment Information
_____ Physician notes related to fine motor, mobility, sensory awareness, and ADL's
_____ Other

_____

to and from the following persons or agencies:

Name	Address	Phone Number
Name	Address	Phone Number
Name	Address	Phone Number

In consideration of treatment and educational purposes, I give consent that sound recordings, records, and/or photographs may be used as deemed helpful by the staff.

This form has been fully explained to me/us and I/we understand the contents.

Name	Date	Relationship to the Client
Witness	Date	Position

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Website/Video Release Form

I hereby authorize Therapy Specialists of Georgia to use:
_____ My Picture
_____ My Video Image including Speech

My image may be used for:
_____ Reports sent to insurance companies, referring physicians and families
_____ Advertising purposes
_____Website

Limitations:
_____ None
_____ Other (Please List)

_____ _____
Patient/Guardian Signature

_____
Date

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Authorization to Bill Credit Card for Services

I _____, authorize Therapy Specialists of Georgia to bill my credit card for therapy services rendered, late cancellations, and/or no-show fees. I understand that I have the right to cancel this automatic payment option at any time. This form is valid for one year and a written request to cancel must be provided to Therapy Specialists of Georgia before the 12 month term. The recurrent billing will automatically terminate upon the discharge of services if no balance remains.

I authorize Therapy Specialists of Georgia to keep my signature on file and to charge my account for the balance of charges not paid by insurance within 60 days and not to exceed $_____. My credit card information is as follows:

_____
Name on Card
Type of Credit Card (please circle) VISA MASTERCARD DISCOVER
_____/_____/_____
Credit Card # Exp. Date 3 digit CCV#
Billing Address: _____
Please check the the debits that your authorize:
____ Co-payments
____ Deductibles
____ No show
____ Late cancellations charges
____ All visits from _____ to _____
____ Recurring charges of $ _____
Circle one: Monthly Weekly
Special Instructions: _____

_____
Signature

_____
Date

_____
Patients Name

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*I have read and understand this privacy policy.

_____
Signature of Patient or Patient Representative

_____
Date

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