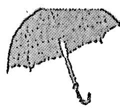


THERAPY SPECIALISTS *of Georgia*

"Covering Everything Under the Umbrella"

4550 Arkwright Road, Macon GA 31210 O: 478-477-0601 F: 478-477-0133

Kay W. Hancock, Owner

Patient Information sheet

Patient Name: ______________________ Date: ____________

Address: ____

____

Patient DOB: __________ SEX M F

Parent /Guardian Mother: ______________________ DOB ______________________

Social Security Number: ______________________ Home Number: ______________

Work Number: ______________________ Cell Phone Number: ______________

Parent/Guardian Father: ______________________ DOB ______________________

Social Security Number: ______________________ Home Number: ______________

Work Number: ______________________ Cell Phone Number: ______________

Primary Insurance: ______________ Secondary Insurance: ______________

Address: ______________ Address: ______________

Phone: ______________ Phone: ______________

Name of Insured: ______________ Name of Insured: ______________

DOB of Insured: ______________ DOB of Insured: ______________

Insured SS# ______________ Insured SS# ______________

Group: ______________ Group: ______________

Policy # ______________ Policy # ______________

DOES YOUR CHILD RECEIVE SERVICES AT SCHOOL : ____YES ____NO (IF SO PLEASE CHECK WHICH ONE)

_____ IEP _____ 504 _____ BCW (Babies Can't Wait)

WHICH SERVICES DOES CHILD RECEIVES? _____ PT _______ OT ________ST

WHAT SCHOOL DOES CHILD ATTEND:

____

THERAPY SPECIALISTS *of Georgia*

"Covering Everything Under the Umbrella"
4550 Arkwright Road, Macon GA 31210 O: 478-477-0601 F: 478-477-0133
Kay W. Hancock, Owner

Please complete the other side.

HAS YOUR CHILD RECEIVED SERVICE FROM ANOTHER THERAPY CLINIC IN THE LAST 6 MONTHS?
_____ YES _____NO

IF YES WHICH CLINIC.________________________________ **PHONE:** ____________________

Name of Patient Primary Doctor: ____

Telephone number for Doctor: ____

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 service not covered by my insurance.

Signature of Responsible Party: ____

Date: ____

Please return to the front desk when finished with:

________ Id Card

________ Insurance Card

________ Sign Release of Information for School/ (If needed)

THERAPY SPECIALISTS of Georgia

"Covering Everything Under the Umbrella"

4550 Arkwright Road, Macon GA 31210 O: 478-477-0601 F: 478-477-0133

Kay W. Hancock, Owner

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

THERAPY SPECIALISTS of Georgia

"Covering Everything Under the Umbrella"

4550 Arkwright Road, Macon GA 31210 O: 478-477-0601 F: 478-477-0133

Kay W. Hancock, Owner

Website/Video Release Form

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

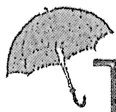
My image may be used for:
________ Reports sent to insurance companies, referring physicians and families
________ Advertising purposes
________Website

Limitations:
________ None
________ Other (Please List)

______________________________ ____________________
Patient/Guardian Signature

____
Date

4550 Arkwright Road
Macon, GA 31210
Phone: (478) 477-0601
Fax: (478) 477-0133
http://www.therapyspecialistsofgeorgia.com



THERAPY SPECIALISTS of Georgia

"Covering Everything Under the Umbrella"

4550 Arkwright Road, Macon GA 31210 O: 478-477-0601 F: 478-477-0133
Kay W. Hancock, Owner

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:

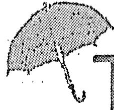
____
Name on Card
Type of Credit Card (please circle) VISA MASTERCARD DISCOVER
___________/_____________/_________________
Credit Card # Exp. Date 3 digit CCV#
Billing Address: ____
Please check the the debits that your authorize:
_____ Co-payments
_____ Deductibles
_____ No show
_____ Late cancellations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

____
Signature

____
Date

____
Patients Name

4550 Arkwright Road
Macon, GA 31210
Phone: (478) 477-0601
Fax: (478) 477-0133
http://www.therapyspecialistsofgeorgia.com



THERAPY SPECIALISTS of Georgia

"Covering Everything Under the Umbrella"

4550 Arkwright Road, Macon GA 31210 O: 478-477-0601 F: 478-477-0133

Kay W. Hancock, Owner

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

4550 Arkwright Road
Macon, GA 31210
Phone: (478) 477-0601
Fax: (478) 477-0133
http://www.therapyspecialistsofgeorgia.com

THERAPY SPECIALISTS of Georgia

"Covering Everything Under the Umbrella"

4550 Arkwright Road, Macon GA 31210 O: 478-477-0601 F: 478-477-0133
Kay W. Hancock, Owner

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.

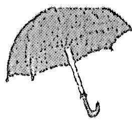
I am fully aware that I am to pay my balance in full before the time of service and that if I cannot pay, I will be turned away for services until my balance is paid. I understand that I will be charged a late cancellation fee for cancelling past 9:00 on the day of service and I will be charged a no-show 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

4550 Arkwright Road
Macon, GA 31210
Phone: (478) 477-0601
Fax: (478) 477-0133
http://www.therapyspecialistsofgeorgia.com



THERAPY SPECIALISTS of Georgia

4550 Arkwright Road, Macon GA 31210 478-477-0601 F: 478-477-0133

Kay W. Hancock, Owner

Telehealth Patient Consent Form

I (name) ______________________________________ agree to receive this health care service, **Physical, Occupational, Speech Therapy** as a Telehealth service. I understand that the health care practitioner Therapy Specialists of Georgia located in another facility (facility name and address) **Therapy Specialists of Georgia, 4550 Arkwright Road Macon, GA 31210.**

A Telehealth service means that my visit with a practitioner at the distant site will happen by using special audiovisual equipment. This consent is valid for six months for follow-up Telehealth services with the health care provider.

I also understand that:

- I can decline the Telehealth service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- I may have to travel to see a health care practitioner in-person if I decline the Telehealth service.
- If I decline the Telehealth services, the other options/alternatives available for me, including in-person services, are as follows: **seek alternative providers in your community.**
- The same confidentiality protections that apply to my other medical care also apply to the Telehealth service.
- I will have access to all medical information resulting from the Telehealth service as provided by law.
- The information from the Telehealth service (images that can be identified as mine or other medical information from the Telehealth service) cannot be released to researchers or anyone else without my additional written consent.
- I will be informed of all people who will be present at all sites during my Telehealth service.
- I may exclude anyone from any site during my Telehealth service.
- I may see an appropriately trained staff person or employee in-person immediately after the Telehealth service if an urgent need arises OR I will be told ahead of time that this is not available.
- I also understand that my insurance will be billed for this visit with consulting health care provider, (name of provider) **Therapy Specialists of Georgia** , and that I may be billed for what my insurance does not cover, dependent upon the provider. I understand that if I have any questions about my billing, I will need to talk with the provider's billing office. Therefore, by signing this consent, I am giving permission to release information to my insurance company or third party payor.
- I give permission for Therapy Specialists of Georgia to provide limited information to the coordinator at this site for billing purposes.

I have read this document carefully, and my questions have been answered to my satisfaction. I understand that this consent is valid for six months.

______________________________________ ______________

Signature of Patient — Date

______________________________________ ______________

Signature of Parent or Legal Representative — Date

______________________________________ ______________

If other than patient, relationship to patient — Reason (minor, incompetent, etc.)

______________________________________ ______________

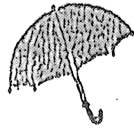
Witness — Date

Telehealth Consent:

______________________________________ ______________

Signature of Person Obtaining Consent — Date

Copy Given to Patient



THERAPY SPECIALISTS of Georgia

4550 Arkwright Road, Macon GA 31210 114 Constitution Drive, Suite 300, Warner Robins GA 31088

O: 478-477-0601 F: 478-477-0133 Kay W. Hancock, Owner

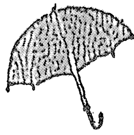
Thank you for continuing to trust our practice for your therapy needs. As with the transmission of any communicable disease like a cold or the flu, you may have been exposed to COVID-19 (also known as the Coronavirus) at any time or in any place. As always, we strive to provide a safe and clean therapy environment, and continue to practice universal personal protection as well as the disinfection protocols recommended by the Center for Disease Control (CDC) to limit the transmission of all diseases in our facility.

Despite our careful attention to sterilization, disinfection, and use of personal protection equipment, there is still a chance that you could be exposed to an illness in our office. "Social Distancing" nationwide has helped to reduce the spread of the Coronavirus. We will continue to work to provide social distancing as much as possible, however, it is difficult to do so at all times given the nature of our practice and the need to interact closely with the client.

Although exposure is unlikely, do you accept the risk and consent to in-person treatment?

Yes ___ No ___

Patient's Name & Date of Birth	Date
Patient / Guardian's Signature	Relationship to Patient



THERAPY SPECIALISTS of Georgia

4550 Arkwright Road, Macon GA 31210 114 Constitution Drive, Suite 300, Warner Robins GA 31088

O: 478-477-0601 F: 478-477-0133 Kay W. Hancock, Owner

Have you or anyone in your home had any of the following symptoms in the past 48 hours?

Yes	No	
____	____	Fever (anything 100.4 and above is considered a fever)
____	____	New or worsening cough
____	____	Shortness of breath or difficulty breathing
____	____	Fatigue
____	____	Muscle or body aches
____	____	Headache
____	____	New loss of taste or smell
____	____	Sore throat
____	____	Congestion or runny nose
____	____	Nausea or vomiting
____	____	Diarrhea

____ ____ Have you or anyone in your home been tested for or diagnosed with COVID-19 (Coronavirus) in the last 14 days?

____ ____ Have you or anyone in your home been exposed to someone who has been tested for or diagnosed with COVID-19 (Coronavirus) in the last 14 days?

By signing this document, I acknowledge that the answers that I have provided above are true and accurate to the best of my knowledge.

______________________________ ______________________________
Patient's Name & Date of Birth Date

______________________________ ______________________________
Patient / Guardian's Signature Relationship to Patient

THERAPY SPECIALISTS of Georgia

"Covering Everything Under the Umbrella"

4550 Arkwright Road, Macon GA 31210 O: 478-477-0601 F: 478-477-0133
Kay W. Hancock, Own

Confirmation of Appointment and Cancellation Policy

Our desire is to provide every patient with the consistent treatment they need, along with the special attention they deserve. As a courtesy to our patients, we call 1 business day prior to the appointment to remind you of your time and to answer any additional questions you may have. If we are unable to reach you to confirm your appointment by 3PM the business day prior, we reserve the right to schedule someone else in that slot. Please ensure you have provided us with the phone number(s) where we can best reach you or leave a message during daytime hours. If you know you will be unable to keep your appointment, please call us as soon as possible.

We are unable to provide treatment to those who are more than 15 minutes late for their appointment. Therefore, it will be considered a Late Cancellation and you will not be seen that day. Your appointment may be rescheduled for another day within the week in order to avoid the fee. Anyone who repeatedly shows late will forfeit their appointment and will be seen on a Call-In Basis.

In order to accommodate all our patients' needs, we ask that you provide a 24 hour notice if you are unable to keep a scheduled appointment. Failure to provide a 24 hour notice, may result in a **$40.00 Late Cancellation fee**. If an appointment is confirmed, but the patient fails to show, a **$50.00 No Show fee** will be applied. Late Cancellation and No Show fees MUST be paid before the next appointment. We understand that circumstances arise that are beyond your control, therefore we may waive this fee on a case-by-case basis. Once a patient breaks 3 appointments in our practice within a 1 year period, they will be seen on a Call-In Basis and will not be given a recurring appointment slot. Should you continue missing appointments you will be discharged from therapy and a note will be sent to the referring physician.

Signature ______________________________ Date ______________

Witness ______________________________ Date ______________