TheraSens, Inc.

1900 Garden Road, Suite 200 Monterey, CA 93940 PHONE: (831) 250-6770 FAX: (831) 250-6767

Patient Information

(PLEASE PRINT AND FILL OUT ENTIRELY)

DATE_____ PATIENT'S NAME_____DOB_____
Last First MI

SEX: F___M___ PATIENT'S PRIMARY PHYSICIAN: _____
NAME ADDRESS PHONE FAX

OTHER SPECIALTY PHYSICIANS: (please name) _____

IS THE PATIENT ALLERGIC TO ANY MEDICATIONS or FOODS: _____

PLEASE LIST CURRENT MEDICATIONS PATIENT IS TAKING: _____

IS THE PATIENT'S IMMUNIZATIONS UP TO DATE (if not EXPLAIN): _____

WHO REFERRED YOU TO THERASENS OCCUPATIONAL THERAPY_____

PARENT'S (1) NAME_____ DOB_____ SS#_____-_____-_____
LAST FIRST M.I.

PARENT'S (2) NAME_____ DOB_____ SS#_____-_____-_____
LAST FIRST M.I.

PARENT EMAIL ADDRESS_____CELL PHONE ( ) _____

MAILING ADDRESS_____
STREET CITY STATE ZIP

EMPLOYER (1) _____ PHONE ( ) _____

BUSINESS ADDRESS_____

PARENT (2) EMPLOYER _____ PHONE ( ) _____

BUSINESS ADDRESS_____

RELATIVE OR FRIEND WE MAY CONTACT IN AN EMERGENCY: NAME_____

ADDRESS_____ PHONE ( ) _____ CELL ( ) _____

A COPY WILL BE MADE OF YOUR INSURANCE CARD IF YOU HAVE INSURANCE FOR WHICH WE ARE A PROVIDER OR WHICH WE MAY BILL. CO-PAYS ARE DUE PRIOR TO TREATMENT. FULL PAYMENT IS DUE PRIOR TO TREATMENT IF YOUR INSURANCE WILL NOT BE UTILIZED. IT IS YOUR RESPONSIBILITY TO CONACT YOUR INSURANCE TO DETERMINE COVERAGE.
PLEASE REMEMBER THAT PAYMENT IS YOUR OBLIGATION REGARDLESS OF INSURANCE OR OTHER THIRD-PARTY INVOLVEMENT

SIGNATURE OF PERSON RESPONSIBLE_____

Assumption of Risk, Waiver of Liability, Medical Authorization

Patient's Name _____

Phone Number _____ Cell Number _____ Work Number _____

Address _____
Street City State Zip

Emergency Contact (other than yourself) _____

Phone Number _____ Cell Number _____ Work Number _____

Address _____
Street City State Zip

I recognize that potentially severe injuries, including but not limited to permanent paralysis or death can occur in sports or activities involving height or motion, including but not limited to gymnastics, tumbling, trampoline, stairs, dance, rock climbing, swinging and running. Being fully aware of these dangers, I voluntarily consent to the person(s) participating in any and all Therasens, Inc. programs and activities, and I KNOWINGLY ACCEPT FULL RESPONSIBILITY AND ASSUME ALL RISKS associated with that participation. In consideration for allowing the above-mentioned person(s) to obtain Occupational Therapy instruction, I, on my own behalf and the behalf of the above-mentioned person(s) and our respective heirs, administrators, executors, and successors, hereby COVENANT NOT TO SUE or TRY TO COLLECT DAMAGES IN ANYWAY and FOREVER RELEASE Natalie Sanders personally and Therasens, Inc., its officers, directors, shareholders, employees, contractors, or agents from all liability for any and all damages or injuries suffered by the above-mentioned person(s) while under instruction, supervision or control of Therasens, Inc., including without limitation, those damages or injuries resulting from acts of negligence on the part of its officers, directors, shareholders, employees, agents, or Natalie Sanders. I agree to INDEMNIFY AND HOLD such individuals HARMLESS from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees brought as a result of such participation in Therasens Inc. programs and activities and to reimburse them for any such expenses incurred. I expressly acknowledge and agree that this agreement is intended to be as broad and inclusive as is permitted by the law of the State of California and that if any portion is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. In the event of an emergency, I would like the above-mentioned person(s) to be taken to a hospital for medical treatment and I hold Therasens, Inc., Natalie Sanders and its representatives harmless in their execution of this action. Additionally, I hereby agree to individually provide for all possible future medical expenses which may be incurred by my child as a result of any injury sustained while participating in Therasens, Inc. I have read and understand this ASSUMPTION OF RISK, WAIVER OF LIABILITY and MEDICAL AUTHORIZATION and I VOLUNTARILY affix my name in this agreement.

Legal Guardian Signature _____ Date _____

AUTHORIZATION FOR APPOINTMENT REMINDER

By signing below indicates that you approve being contacted for appointment reminders by:

____ Email ____ Text

Signature: _____ Date: _____

TheraSens, Inc.

Recognition of TheraSens Policies & Patient Responsibilities

Patient Name: _____ DOB: _____

1. It is the patient/parent(s)/guardian(s) responsibility to inform TheraSens, INC. 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. ____ Initial

2. It is the patient/parent(s)/guardian(s) responsibility to attain authorization and approval for therapy with insurance companies, including Blue Cross, that TheraSens, INC. does not contract with or is considered out of network. ____ Initial

3. It is the patient/parent(s)/guardian(s) responsibility to understand their own insurance policy regarding their deductibles, co-pay amounts, and number of allied health visits authorized and approved for the year. ____ Initial

4. No-Shows and Cancellations: Appointments are a contract for the exclusive use of the therapist's time. Parents will be charged $75 (no-shows/late cancellations) $100 initial evaluation. Cancellations are late when given less than a 24-hour notice. Termination of services may occur if patients are not consistently attending their scheduled time. 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. We understand that there will be unavoidable circumstances that may come up. For us to plan appropriately for staff, we require that parents call to cancel their appointment for illness or an unavoidable conflict as soon as possible. _____ Initial

5. 3. For your convenience, TheraSens, INC. allows parents/legal guardians or caregivers to leave the premises during their child's appointment. However, it is very important to be back on the premises at the end of your child's treatment, so the therapist can discuss treatment with the parent/legal guardian or caregiver and to ensure your child's safety if there is no one that can stay with your child. ____ Initial

6. If TheraSens, 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. TheraSens, INC. must have a cell phone number to reach you before leaving. ____ Initial

7. TheraSens, 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, and 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. ____Initial

8. Out of pocket Policy: Insurance policies are contracts made between the patient and the insurance company. When insurance does not provide payment of therapy costs, payment of the bill is your responsibility. If for any reason treatment is denied by your insurance, we will charge for the usual and customary amount paid by your insurance company. _____Initial

9. Both private insurers and the Federal Government prohibit waiving and/or reducing the co-payments and deductible amounts due. Due to company and industry wide standard ethics, we are required to collect all copayments and deductibles that are due by your specific policy. We are obligated to follow these standards. _____Initial

10. Occasionally we have trained volunteers completing their hours for occupational therapy, physical therapy, and other health related science programs. TheraSens, INC. plays an important role in helping students in their professional development. Initialing indicates that you give permission for the volunteers to shadow treatments or assist the therapist as needed when working with your child. Volunteers are screened and are required to abide by HIPAA confidentiality policies. ____Initial

_____ _____

Patient Signature or Legal Guardian Date