Patient's Full Name:

PATIENT INFORMATION

Child's Last Name: First: Middle:	Birth Date:	Age:	Sex:
Parent/Guardian Name:			
Street Address:	City, State Zip Code:		
Social Security #	Driver license:		
Home Phone:	Mobile Phone:	Email:	
Physician (s): (if group, please provide practice name and name of primary physician)			
Physician's address:			
Physician's Phone:	Physician's Fax:		
Specialists:			
Referred by:	Diagnosis:		

PRIMARY INSURANCE INFORMATION			
(PLEASE PROVIDE A FRONT AND BACK COPY OF YOUR INSURANCE CARD)			
Primary Insurance Company:	Type: (PPO, POS, HMO)		
Primary Insured Name:	Birth date:	Address (if different)	Home Phone:
Member ID:	Group:	Employer:	
Insurance Carrier's Mailing Address:			

SECONDARY INSURANCE INFORMATION			
(PLEASE PROVIDE A FRONT AND BACK COPY OF YOUR INSURANCE CARD)			
Secondary Insurance Company:	Type: (PPO, POS, HMO)		
Secondary Insured Name:	Birth date:	Address (if different)	Home Phone:
Member ID:	Group:	Employer:	
Insurance Carrier's Mailing Address:			

Patient's Full Name:

HIPAA PRIVACY PRACTICES

The purpose of this notice is to ensure that you (the patient) or your designated representative is made aware of your rights to ensure the privacy of your healthcare information. ATI retains the right to update this notice at any time. You will be notified of any changes and you will receive an updated copy from the office upon request.

1. **Privacy of Patient Information:** We have created a record of the services and treatment that you receive at Associated Therapies Inc. The privacy of your medical information is important to us and we are committed to protecting it. We are required by law to keep your medical information private and notify you of legal rights and privacy practices.

2. **Use and Disclosure of Patient Information:** Your child's therapy information will be used for treatment, payment and to communicate with other healthcare professions, payers, state and federal entities as well as law enforcement agencies in the interest of public safety or authorized educational institutions. HIPAA allows disclosure of this information to your designated contact which you may specify below:

Name of Designated/Authorized contact:	
Relationship to Patient:	
Authorization to disclose to or receive from (School or Healthcare Provider name):	

3. **Patient (or Designee's) Personal Communication:** You may communicate confidential information, including services, to me by the following means:

Mailing Address:	
Home Phone:	
Cell Phone:	
Email:	
Patient's Date of Birth:	

4. **Patient's Access to Medical Information:** You have the right to see and obtain a copy of your medical records at any time. You may request changes to your health information. If ATI does not agree with your changes, you must be allowed to insert a statement of disagreement into the patient's record. ATI is not required to agree with your changes. You may request the reason for any disclosures made on your behalf.

5. **Confidentiality of Patient Information:** Associated Therapies, Inc. will attempt in all cases to preserve the confidentiality of all oral and written medical information. This includes patient records, written information and electronic transmission of information to physicians, insurance companies, state and federal entities and law enforcement agencies in the interest of public safety. Associated Therapies, Inc. will not be held responsible in the event of natural disasters, theft or burglary of their physical and electronic property having taken reasonable precaution.

6. **How to file a Complaint**: You may file a complaint if you feel that your privacy rights have been violated. Please ask for a complaint form. ATI will not retaliate against you if you file a complaint. Complaints should be directed to the privacy officer.

7. Associated Therapies Inc Contact Information: You may contact the Practice Administrator at 404-728-9766.

Patient's or Designee's Signature:______________________________ Date: __________________________________

Patient's Full Name:

Billing Policy and Procedures

______1. We will bill your insurance as a courtesy to you. However, it is your responsibility to assist in the prompt receipt of payment from your insurance company and you are responsible for any unpaid charges, including co-payments/co-insurance.

______2. You must inform Associated Therapies, Inc. of any changes in your insurance, Medicaid or Babies Can't Wait coverage. Failure to notify us of changes will result in parent or legal guardian being responsible for payment.

______3. Parent or legal guardians are responsible for payment of services if insurance or secondary plan coverage does not cover a date of service or is terminated.

____4. Any invoice that is not paid within 14 days will receive a phone call or follow-up invoice with rebilling charge of 10%. Any invoice not paid within 45 days will be turned over to collections with additional 33% collection fee and or charged on the credit card provided.

______5. Continuation of therapy services is contingent upon timely payment of all bills

______6. Parent or guardian is also responsible for all the charges, if the child becomes ineligible for Medicaid, and he/she is not enrolled in Babies Can't Wait program, as well as non-covered Medicaid services.

______7. If account is turned over to collections, an additional collection fee of 33% will be added to your total account.

______8. A copy of your Medicaid and/or Insurance card will need to be faxed/mailed to our office.

______9. If you need special assistance to pay your portion of therapy charges, please don't hesitate to call our office. We will be happy to develop a payment plan to assist you.

______10. ATI will send an invoice based on the EOB that insurance has sent to ATI. Patient understands that insurance may take 30-180 days or more to send EOB's to ATI.

______11. Verification of benefits is NOT a guarantee of coverage or payment by insurance. This information is provided to us by your insurance company and is subject to change at any time. Any amount that your insurance company does not cover are your responsibility to pay in full within 14 days of invoice being sent to you.

______12. Keeping track of your number of covered visits per calendar year. ATI WILL NOT keep track of your number of visits used and visits left. If you exceed that maximum number of visits a provided by your insurance coverage, YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL within 14 days of invoice being sent to you.

I understand and accept the billing policies and procedures listed above.

________________________________ ____________________________

Parent or Guardian Signature Date

I authorize payment of medical benefits and/or government benefits to Associated Therapies, Inc

________________________________ ____________________________

Parent or Guardian Date

I authorize ATI to file a complaint to the insurance commissioner on my behalf.

________________________________ ____________________________

Parent or Guardian Date

Patient's Full Name:

Fees and Payment Policies

Associated Therapies is here to provide your child with quality therapy services. We established fees that enable us to have the quality staff and facilities that are necessary to provide the care you expect. This explanation of our payment policies has been prepared so that you can help us maintain quality services. Like you, we are concerned about the cost of health care. Our payment policies are designed to enable us to reduce unnecessary collection costs, which would otherwise increase the cost to you.

Your responsibility for charges

You are ultimately responsible for the payment of charges for services you receive. If payment is to be made through insurance medical plan and we have agreed to accept assignment from that plan, then you are responsible for complying with any procedures required by that plan to enable us to receive payment on your behalf. To assure that your insurance or medical plan will provide covered benefits, you must let us know how you plan to provide payment for your visits. If you will be paying personally for the services or if you are responsible for deductible or co-payment, we expect payment at the time service is rendered. We accept check, cash, credit cards (visa, MasterCard and discover). If you are experiencing personal circumstances that will make the payment of our charges difficult for you, please ask to speak with our Business office personal.

We will also do our best to receive authorization for the services. However, it is ultimately parents'/caregiver's responsibility to follow through with the insurance company. If for any reason insurance denies benefits or payment for the services, parents are responsible for the payment regardless of the outcomes. Associated Therapies contacts the insurance company for authorization/benefits as a curtesy for our clients. It is parents'/caregiver's responsibility to contact the insurance company and be clear on their policy and its benefits as well as authorization. Verification of benefits is not a guarantee of payment by insurance. Patient is ultimately responsible for any amounts that insurance does not cover for any reason.

PPOs, POS, and Government Plans

As a convenience to our patients, we participate with many PPOs, POS and government medical plans currently offered in this area. In order for our services to be covered under your plan, both parties must comply with the plan's requirements. It is your responsibility to know your plan's requirements for coverage. We will assist you with what we know; however, since these are "your" plans, we cannot make final determination regarding coverage; this must be done by your insurance company. Co-payments are to be presented at check in at the time of each visit.

______ initials

Patient's Full Name:

Patient Consent Form

I, ______________________________, hereby authorize Associated Therapies, Inc. to evaluate and treat ____________________________ for pediatric physical, speech or occupational therapy.

I understand that the client's protected health information may be used and disclosed to carry out treatment, payment or healthcare operations. For a more complete description of the potential uses and disclosures of the protected health information, please refer to the Notification of Privacy Practices issued on the first day of treatment. If you have misplaced your copy, please feel free to contact our office at 404-728-9766 and we will mail one to you. The Notice of Privacy Practice may change and you have the right to an updated copy. To receive a copy, please contact us at the above number. You have a right to review the Notice of Privacy Practices prior to signing this consent. If you have any questions, you may contact our privacy officer, Humera Savaja at 404-728-9766 ext 12

Please note that you have the right to request that Associated Therapies, Inc, restrict how your protected health information is used or disclosed to carry out treatment, payment or health care operations. It should be noted that the provider is not required to agree to requested restrictions; however, if the provider agrees to a requested restriction, the restriction is binding on the provider.

You have a right to revoke the consent in writing, except to the extent that the provider has taken action in reliance on it.

I give consent to leave a message on my voicemail system regarding my child and his/her care.

____ ____________________________

Parent or Legal Guardian Date

Patient's Full Name:

Notice of Privacy Practices

I, ________________________________, have been issued a copy of Associated Therapies, Inc. Notice of Privacy Practices. If there are any questions regarding this notice, I understand that I may contact the privacy officer, Humera Savaja at 404-7289766 ext 12

____ ___________________________

Parent or Legal Guardian Date

I understand that I have the right to review this office's Notice of Information Practices as displayed in the waiting room.

I have received a copy, and read the Notice of Information Practices posted in this office and understand its meaning. I understand that I have the right to request that this provider restrict how protected health information is used or disclosed to carry out treatment, payment or healthcare operations. And that the provider is not required to requested restrictions. I have the right to revoke the consent in writing except to the extent that the provider has taken action prior to the revocation. I understand that this authorization is voluntary.

____

Signature of patient or patient's representative Date

Printed name of patient's representative: _________________Relationship to Patient: _________________

Patient's Full Name:

Client's Pediatrician / Clinical Office

ATI will contact your doctor / previous therapy clinic to obtain the following:

1. Script for Therapy or referral
2. Evaluations or notes to help with therapy.
3. All informational notes required to help us better the services for the child.

ATI will try to obtain the above mentioned information from your doctor's office / therapy clinic within the 7 days of the child being scheduled for their initial appointment. After 7 days it will fall to the responsibility of the child's parent / guardian to obtain the required above mentioned information. Failure to provide the required above mentioned information will result in your child not been seen by the therapist/s and any subsequent fees the parent will be liable to pay ATI.

____
Signature of patient or patient's representative Date

Printed name of patient's representative: ________________Relationship to Patient: ________________

Patient's Full Name:

Credit Card Information

In the event a bill from Associated Therapies, Inc has not been paid within 60 days, I authorize payment of any outstanding balance with the following credit card:

Credit Card type: ____Visa____Mastercard____Amex_____Discover

Nam on the Card:____

Card Number:____

Expiration date:__________________

3 digit code:___________________ 4 digit in case of Amex

Billing address where card is billed:

Street Address:____
Apt:____
City:________________ State:________________zip code:________

Signature of the card holder for authorization ______________________

**This option will only be exercised in the event of non-payment of outstanding balances of 60 or more days past due. You can also use this as regular payment option.

Patient's Full Name:

POLICY REGARDING CANCELLATIONS AND "NO SHOWS"

In an effort to be respectful of your busy schedule and our therapist; and secondary to the large waiting list and the high demand for therapy services, Associated Therapies, Inc employs an attendance policy for all scheduled therapy appointments.

Planned Cancellations: (doctor's appointment, vacation)

- It is the parent's/caregiver's responsibility to keep the therapist informed of any changes they need to make in their scheduled therapy visits. We request a 48-hour notice of any cancellations so that adjustments can be made and make up sessions scheduled if possible.

- Our Therapist will give a minimum of 48-hour notice for any cancellations they need to make with regard to your scheduled visits.

Cancellations Due to Illness:

- It is important that both the parent/caregiver and therapist be respectful of health concerns. *Children with diarrhea, vomiting, contagious diseases and/or a temperature above 100 degrees* should not be seen to ensure the health of the therapist and other patients being treated.

- Should your child (or another child in the home who will be there during therapy time) wake up with any of these symptoms, please contact your therapist as soon as possible. Your therapist will likewise call as soon as possible should she/he be ill and not be able to render services to your child. Your child should be symptom free for 24 hours before resuming therapy.

"No Shows": □ in the event of a "no show" (not showing up at the clinic or not being at home at the scheduled time), you will be given written notice with $ 50 "no show "**without prior notification.** A second "no show" within a 3 month period will result in the child being discharged from your therapist's caseload.

Your Therapist will make every effort to reschedule your child when a cancellation is required. Parents must keep 75 percent of scheduled therapy visits per month. Clients who drop below this amount for 2 consecutive months will be given written notice of discharge from my caseload.

I have read the above attendance policy with regard to cancellations and "no shows" for scheduled therapy visits.

________________________________ ____________________

Parent/caregiver signature Date

Patient's Full Name:

CONSENT TO RECEIVE EMAIL AND/OR TEXT MESSAGES

We can email you and or text you to remind you regarding your appointments. If you would like to receive these reminders in the future, please read the consent below and sign. Patients in our practice may be contacted via email and or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, to email you invoice, and to provide general health information.

☐ I consent to receive emails from ATI office and or therapists at my email address provided below

The email that I authorize to receive email messages for appointment, invoices, feedback requests and general health information is:

____

Please write legibility

☐ I consent to receive text messages from ATI office at my cell phone number provided below. If there are any charges that may apply from my service provider is my responsibility.

The cell phone number that I authorize to receive email messages for appointment, invoices, feedback requests and general health information is:

(______) __________-______________________
Please write legibly

I understand that this request to receive emails and/or text messages will apply to all future appointment reminders, feedback and general health information unless I request a change in writing to ATI and the Therapist.

Parent Signature ______________________________________ Date ______________________________________

Print Name: ____