3203 VIneville Ave. Macon, Georgia 31204 (478) 731-9477
www.thetherapyconnectionmacon.com * thetherapyconnection@gmail.com

Registration Information Client Name (Last, First):
_____

Date of Birth: _____ Male_____ Female _____

Diagnosis _____

(Please include ICD-9 Code)

Parent/Guardian: _____

Home Address: _____

City / State / Zip: _____

Home Phone: _____

Work Phone: _____

Primary Insurance: _____

Policy Holder: _____ Policy Holder's Date of Birth: _____

Policy #: _____ Group #: _____

Address to File Claims:
_____
_____Customer Service Phone#: _____ Employer:
_____ Secondary Insurance:
_____

Policy Holder: _____

Policy Holder's Date of Birth: _____

Policy #: _____

Group #: _____

Copy of Prescription Attached: _____

Consent, Release and Hippa Forms

Signed On: _____ Child is served by BCW: Yes_____ No _____

New Patient Forms

The following forms must be completed, signed and brought to the first meeting with your therapist:

- Case History Form
- Authorization for the Release of Medical Records
- Acknowledgement of the Receipt of Privacy Policy
- Consent to Bill and Consent to Treat
- A PRESCRIPTION from your primary care physician (with Diagnosis Code) for OT, ST or PT Evaluation and Treatment. (This is EXTREMELY important so that we can bill your insurance provider.)
- A PHOTOCOPY OF YOUR INSURANCE CARDS (front and back)
- Any prior therapy notes, evaluations and/or medical information that will assist us in treating your child.

Health Privacy Notice Acknowledgements

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to makes changes in our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice Available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or additional copies of this Notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION We use and disclose health information about you for your treatment, payment, and health care operations. For example:

Treatment: We may use and disclose your health information to a physician or other health care provider proving treatment to you. Payment: We may use and disclose your health information to obtain payment services we provide to you. Health care operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence of qualification of health care professionals, evaluating practitioner performance, conducting training programs, accreditation, certification, licensing, and credential activities. Your Authorization: In addition to our use of your health information for treatment, payment or health care operations you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not effect any use of disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those describes in this Notice. To your family and friends: We must disclose your health information to you as described in the Patient

This Policy is Your Copy to Keep & Review

Rights section of this Notice. We may disclose your health information to a family, member, friend or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so. Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, or your location, your general condition, or death. If you are present, then prior to use or disclosure of your

health information, we will provide you with an opportunity to object such uses and disclosers. In the event of your incapability or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information. Marketing Health-related Services: We will not use your health information for marketing communications without your written authorization. Required by Law: We may use of disclose your health information what we are required to do so by law. Abuse of Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may not disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials' health required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances. Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail message messages, postcards, or letters).

PATIENT RIGHTS Access: you have the right to inspect and obtain a copy of your protected health information, with limited exceptions. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other cost incurred by us as a result of complying with your request. Requests for access to your protected health information must be made in writing. Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other that treatment, payment, health care operations and certain other activities, for the last 6 years. You must make your request in writing. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee responding to these additional requests. Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). You must make your request in writing. Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternate locations. (You must make your request in writing.) Your requests must specify the alternative means or location, and provide satisfactory explanation will be handled under the alternative means location you request. Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances. Right to Express Complaints: You have the right to express complains to us and to Secretary of the Department of Health and Human Services if you believe that your privacy right has been violated. If you wish to complain to us, you must do so in writing, and direct your complaint to the Privacy Leader.

Right to Obtain a Paper Copy of this Privacy Summary Notice as well as the Full Privacy Notice.

Questions and Complaints If you want more information about our privacy practices, or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services upon request.

We support your right to privacy of your health information. You will not be penalized in any way if you choose to file a complaint with us and / or with the U.S. Department of Health and Human Services.

PROCEDURE FOR PERMISSION TO USE PATIENT PHOTOGRAPH/VIDEO

The Therapy Connection d/b/a Dumas Therapy Inc., Independent Contractors/Companies and affiliates seeks to promote the positive experiences of patients. We would like to publish patient's accomplishments on our web sites,

Facebook Page, or other publications. Most parents enjoy seeing their children's positive activities publicized; however, if you do not want us to release photos of your child, please check no.

I give my permission for photographs/videos or other likenesses of my child to be released to the media (newspapers/TV), web sites and publications. _____ yes _____ no

Parent's Name:_____ Patient's Name: _____

Signature of Parent/Guardian: _____Date: _____

General Information
Child's Name: _____
Date: _____
Birth date: _____
Age: _____ Sex: _____ Male _____Female
Referring Doctor:
_____
_____

Address:_____
_____
_____
_____
Home Phone: _____
Email Address: _____
Do you feel comfortable receiving emails regarding therapy services and your child? _____ yes _____no
School/Preschool:_____ Grade _____
Referred By: _____
Person filling out this form: _____Mother _____Father _____Stepmother _____Stepfather Other: _____

Mother's Name:_____
Cell Phone: _____
Evening Phone: _____
Father's Name: _____
Day Phone: _____
Evening Phone: _____
Marital Status of Parents: _____
Person with whom child resides: _____
Primary Language spoken in the home: _____

PLEASE EXPLAIN THE CONCERNS YOU HAVE ABOUT YOUR CHILD? (Include when this was first noticed and/or what may have caused it, etc): _____
_____
_____
_____
_____
Has your child been enrolled in any type of therapy or other treatment programs and/or received testing?
___Yes ___No
If yes, please describe the program(s):
_____
_____
_____
Medical History: Primary Care Physician:
_____
Phone Number: _____
Developmental Physician: _____
Phone Number: _____

Pregnancy/Birth History: List any problems or unusual stresses during pregnancy:_____
_____
_____
List any problems after birth (i.e.-jaundice, required oxygen, etc):
_____
_____
Birth Weight:_____ Early or Late?:_____
Did child go home with family as expected? _____Yes _____No
List any unusual problems during first few weeks of life:
_____
Health: Has your child has his/her hearing checked? _____Yes _____No Date:_____
Results:_____
_____
Has your child has his/her vision checked? _____Yes _____No Date:_____
Results:_____
_____
History of ear problems? _____Yes _____No
History of allergies, tonsillitis, or asthma? _____Yes _____No
Are there any diagnosed medical, physical, or emotional problems?
_____Yes _____No Please list any mental health diagnosis:
_____
_____
_____
Have there been any serious illnesses, injuries or hospitalizations?
_____Yes _____No
If yes to any of the above questions, please explain and give dates:
_____
_____
Daily Behavior: Does your child have any of the following:
Socializing problems _____Yes _____No
Feeding problem _____Yes _____No
Sleeping problems _____Yes _____No
If you checked yes for any of the above, please explain:_____
_____
_____
How does your child usually let you know, his / her needs? _____
_____
Does your child communicate well with you / others?
_____
Does your child: Answer when you talk to him/her? _____Yes _____No
Talk about what he/she/ is doing? _____Yes _____No
Ask for help? _____Yes _____No
What are your child's interests?_____
_____
_____
Please list your goals for therapy:
_____
_____
_____

Printed Name of Parent/Guardian/Caregiver: _____
Signature of Parent/Guardian/Caregiver: _____
Date: _____

Authorization for the Release of Medical Records

I, _____ as a personal representative of _____(name of minor patient), hereby authorize The Therapy Connection d/b/a Dumas Therapy Inc. to obtain and release all of this patient's medical records, case records, case histories, and/or personal and regular files, for the purpose of financial reimbursement, continuity of care and case management from and to all current and former providers of medical services (to include: Primary care physicians, Psychologists, etc.). I further understand that some therapy services/health care services are provided by independent contractors and their affiliated companies - Please initial: _____. I understand and agree that a photocopy or facsimile of this executed authorization, is as valid as the original. Unless otherwise permitted by law, further release of this information is prohibited without my prior written consent. I fully understand this authorization, and my consent has been made voluntarily.

Printed name of Parent/Caregiver/Guardian: _____

Signature of Parent/Caregiver/Guardian: _____

Date: _____

Acknowledgement of Receipt of Privacy Policy

I, _____ hereby acknowledge that I have read/ received/downloaded a copy of The Therapy Connection d/b/a Dumas Therapy Notice of Privacy Policy Practices, as it relates to my child (name)_____ _____.

Name of Child _____ Name of Parent/Caregiver/Guardian _____

Address of Child_____

Signature of Parent/Caregiver/Guardian
_____Date _____

Cancellation Policy:

You will receive a confirmation text concerning your child's appointment. Cancellation Policy: Your child is allowed one excused absence per discipline. Each additional cancellation will result in a $25 charge, unless rescheduled. After two absences in the same discipline without rescheduling, your child's therapy slot may be compromised. Cancellations must be made at least 24 hours prior to your child's therapy session.

Initials: _____

No-Show Policy:

"No showing" to your child's scheduled session(s) without prior notification will result in a $50 charge per session. This amount will be due in full prior to your child's next scheduled session. Two "no-shows" will result in your child's therapy slot being compromised. Initials: _____

Patient Drop Off Policy (Parents are to Accompany Children at Therapy at All Times)

Due to concerns with our insurance carrier, patients under the age of 18 cannot be present without a parent/guardian during the time of their scheduled therapy appointment. Exceptions are made during the Summer CAMP Program. This policy ensures the safety of our patients, families, and staff. Our facility is not staffed or equipped for direct patient sitting needs. Initials: _____

Consent to Bill and Consent to Treat

I, _____(parent/caregiver), knowing that _____ (child) has a diagnosis requiring Occupational, Speech, or Physical Therapy treatment (OT, ST, PT, Behavioral Services or Counseling Services) voluntarily consent to such care for the aforementioned child by The Therapy Connection d/b/a Dumas Therapy Inc., Independent Contractors/Companies and affiliates as may be beneficial in the professional judgment of the child's therapist(s) and primary care physician. I am aware that no guarantee has been made as to the effect of OT, ST, or PT on my child. Parent Initials _____

I hereby authorize by The Therapy Connection d/b/a Dumas Therapy Inc., Independent Contractors/Companies and affiliates Billing department to bill my insurance company for direct reimbursement of therapy services rendered to my child. Unless otherwise noted, benefit payment will be assigned directly to by The Therapy Connection d/b/a Dumas Therapy Inc., Independent Contractors/Companies and affiliates. I understand that patient or patient's family is responsible to pay all fees accrued, regardless of insurance verification or anticipated insurance coverage, if insurance company refuses to pay provider a portion of the fees or in full. I agree to pay all fees within 30 days after bill has been mailed, and understand that any fees not paid within 30 days will result in a 10% or greater late fee. In the event of a returned or invalid payment, as well as an unpaid balance over 90 days, I agree to pay any and all additional associated banking, legal and/or collection fees. I understand that I am ultimately responsible for payment of all services received. I understand that I am advised to fully know and understand my insurance benefits prior to my child receiving therapy services. I understand that all insurance plans are different and it is impossible for by The Therapy Connection d/b/a Dumas Therapy Inc., Independent Contractors/Companies and affiliates to know the specifics of my plan and/ or if my plan will reimburse for services received. Regardless of insurance verification or anticipated insurance coverage, I agree to pay all fees accrued for services received.

Parent Initials _____

I am aware that gross motor play is often encouraged during therapy. Use of swinging, running, climbing, and jumping assist with a variety of skills and performance components the therapist may need to address. I consent to use of gross motor play and exempt my child, therapist(s) with by The Therapy Connection d/b/a Dumas Therapy Inc., Independent Contractors/Companies and affiliates from any injury resulting from this type of play. Parent Initials _____

I am aware that by The Therapy Connection d/b/a Dumas Therapy Inc., Independent Contractors/Companies and affiliates is a teaching and learning facility. Students and other health care professionals come to this facility to learn and observe treatments being performed or led by my child's health care professional. I give consent for other professionals and students to participate in treatment sessions. I have the right to withdraw this consent on any day if I choose to do so. Parent Initials _____

Parent/Caregiver Signature: _____

Parent/Caregiver Printed Name: _____