Ability Pediatric Therapy

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130 Main St, Clermont, GA 30527

2022 Patient Registration

Date: _____/_____/ 2022__

Last Name: _____ First Name: _____ MI:_____

Nickname: _____ Date of Birth: _____/_____/_____ Gender: Male / Female

Primary Language: _____

Mailing Address:

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: ( ) _____-_____

Primary Contact:

Last Name: _____ First Name: _____

Cell Phone: ( ) _____-_____ Email:_____

Relation: _____ Lives with Patient?: Yes / No

Secondary Contact:

Name:_____ Phone: ( ) _____-_____

Pediatrician: _____ Phone: ( ) _____-_____

Allergies:_____

Medications:_____

HEARING SCREENING:_____

Other Precautions: _____

Information Consent Form

Due to patient confidentiality, please list below if you wish to allow any family members or any close friends to bring your child(ren) into the office for medical care. Also, we may communicate with the following individuals regarding appointments and medical information or course of treatment.

Name: _____Relation: _____ Phone: ( ) _____-_____

Name: _____Relation: _____ Phone: ( ) _____-_____

Name: _____Relation: _____ Phone: ( ) _____-_____

If parents are divorced or separated, please fill out this section:

Who has custody?

_____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? **Yes / No**

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

I understand that this will remain in effect until I give written notice to Ability Pediatric Therapy to remove any of the persons listed above.

_____ Date of Birth: _____/_____/_____

Print Child's Name (One Form Per Child)

_____ _____

Parent/Guardian Signature Date

Picture Policy

Clinic Use

As the parent/guardian of _____, I give permission to use photographs for posting on the bulletin board.

Parent signature: _____ Date: _____

Social Media

I agree to using my child's picture for the Ability Facebook site or media for publication which may include brochure or other printed materials.

Parent Signature: _____ Date: _____

**We will ask permission before sharing any photos of your child*

Attendance Policy

We keep a very busy schedule at Ability Pediatric Therapy, though we try our best to accommodate our clients. If you have a standing appointment, it is necessary that you make every effort to keep that appointment for the benefit of your child, insurance authorization requirements, and respect for your therapist's time.

Please notify the front office 24 hours in advance if you will not be able to make your appointment and to reschedule.

A No Show fee of $25 will be charged for any appointments cancelled less than 24 hrs in advance.

Missed appointments will be documented and will result in the following penalties: Two "no shows" or frequent cancellation above 20% regardless of reason will result in a written warning. Three "no shows" or continued absence will result in a probationary period in which your standing appointment will be lost and you will be responsible for making appointments on a week by week basis. Further issues will result in a discussion of service discontinuation.

Late Policy: We all run behind from time to time and that is understandable. If you are going to be more than 5 minutes late, please call. For occupational and physical therapy appointments, we will treat your child as long as there is at least a 30-minute window available. Speech therapy appointments are only 30 minutes, so please try your best to **be on time**.

If you want to observe the treatment session, that is perfectly fine. We do ask for no distraction while you are in the treatment area. Due to our growing number of patients, we also ask for only one parent/guardian at a time.

Parent Signature: _____ Date: _____

2022 Financial Responsibility and HIPPA

Insurance

Primary Policy: Policy Holder's Name: _____ Policy Holder's Birth Date: _____/_____/_____
Insurance Carrier: _____

ID Number: _____ Group Number: _____

Secondary Policy: Policy Holder's Name: _____ Policy Holder's Birth Date: _____/_____/_____
Insurance Carrier: _____

ID Number: _____ Group Number: _____

I request that payment of authorized insurance benefits be made on my behalf to the provider for any medical services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, my insurance carrier or other medical entity.

I understand that I am financially responsible to Ability Pediatric Therapy for any charges not covered by health care benefits. It is my responsibility to notify Ability of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services received by the provider.

By signing this document, I also acknowledge that I have received or been offered a copy of the Ability's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Signature: _____ Relation:_____Date: _____

Payment or Co-pay is due at the time service is rendered.

Phone 678-616-3099 Fax 770-406-6840

OTHER SERVICES RECEIVED / RELEASE OF INFORMATION

Does your child receive **services at school**? Circle One: Yes or No

If yes, please list the name of the school and your child indicating that:

I authorize the release of current IEP from the local school system, _____ ,

to Ability Pediatric Therapy regarding (child's name) _____ DOB: _____

Parent signature: _____ Date: _____

Please fax records to 770-406-6840

Leigh Corley, PT/OWNER

Ability Pediatric Therapy, LLC
Providing Physical, Occupational and Speech Therapy

Phone 678-616-3099 Fax 770-406-6840

OTHER SERVICES RECEIVED / RELEASE OF INFORMATION

Does your child currently or have they in the past ever received services at **another therapy clinic**?
Circle One: Yes or No

If yes, Type(s) of Therapy Received: PT OT Speech

Last date of service therapy received: _____

Please list the name of the therapy clinic and your child indicating that:

I authorize the release of all therapy documentation from my child's

former therapy office, _____ ,

to Ability Pediatric Therapy regarding (child's name) _____ DOB: _____

Parent signature: _____ Date: _____

Please fax records to 770-406-6840

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Is your child involved in a DCFS case?

If so please fill out the information below.

Case workers name: _____

Case workers phone number: _____

Any other names and numbers we may need:

_____

_____

_____

I give permission to release all information about my child and the case to Ability Pediatric Therapy.

_____

Parent/Guardian Signature

_____

Date

Please fax records to 770-406-6840

Leigh Corley, PT/OWNER