THERAPY WORKS, PC

BILLING INFORMATION

Name of Child_____
Date of Birth:_____Age:_____M/F_____
Parent/Guardian Name:_____
Contact Phone #:_____Email:_____
Home Address:_____
_____
Doctor's Name:_____Phone #:_____
Diagnosis:_____

I DO give permission for Therapy Works to treat my child. ☐

_____
Signature *Date*

Is your child in BCW Program ☐ YES ☐ NO? If no and they are under 3 years old, they may be eligible for services through Babies Can't Wait. Contact Children First at 770-339-5048 for more information.

Does your child have an IEP or 504 (if older than 3 and in school? ☐ YES ☐ NO

Primary Private Insurance Information (Other than Medicaid)
Policyholder_____Policyholder's DOB_____
Insurance Company_____Effective Date of Coverage_____
Policy #_____Group #_____Member ID #_____
Ins. Co. Address_____
_____Phone #_____
If you have a secondary health insurance plan, please provide that information on the back of this form

Assignment of Benefits
I _____, do hereby assign and transfer benefits
for those services provided to my child_____
to the provider of services: THERAPY WORKS, PC
1509 Atkinson Road Suite 1100
Lawrenceville, Georgia 30043

☐ _____
Parent/Guardian Signature *Date*

Support: Code of Georgia Section 33-24,59.3 – State law requires that the insurer honor a duly executed assignment of benefits and issue payment directly to the provider.

Medicaid / Medicaid CMO Information
Medicaid ID Number_____ ☐ Caresource : ☐ Peachstate ☐ Amerigroup
Child's Name as it appears on Medicaid/CMO Card_____
Primary Care Physician if listed on card_____PCP Phone_____

I have carefully completed the above and certify that I have provided correct bill information to be used by Therapy Works, PC. I agree to provide a copy of my insurance and/or Medicaid card to Therapy Works. I agree to immediately notify Therapy Works of any changes to the above billing information. I agree that failure on my part to provide up to date insurance and/or Medicaid information on my child will result in Therapy Works directly billing me for all charges incurred and Therapy Works will not back bill any charges incurred. I understand that I am ultimately responsible for all charge incurred by my child.

☐ _____
Yes *Parent/GuardianSignature* *Date*

THERAPY WORKS, PC

PATIENT CASE HISTORY FORM

Kindly complete this as part of your child's evaluation.

Name of Child			
Date of Birth		☐ Boy	☐ Girl
Doctor's Name:			
Doctor's Phone Number:			
Diagnosis (if any)			

Please list the major concerns you have in seeking help for your child.

1. _____
2. _____
3. _____
4. _____
5. _____

BIRTH HISTORY		
Was there anything unusual about the pregnancy or birth? (difficult pregnancy, bed rest, premature, difficult birth etc.)	☐ Yes	☐ No
If so, please describe.		

DEVELOPMENTAL HISTORY			
Sit alone	_____	Feed self-finger foods	_____
Crawl (hands & feet)	_____	Speak first real words	_____
Stand alone	_____	Speak first real sentences	_____
Walk well	_____	Become completely toilet trained	_____

MEDICAL HISTORY		
Has child had any significant health problems?	☐ Yes	☐ No
If YES, please describe.		
Does child take medication on a regular basis?	☐ Yes	☐ No
Please list medication taken and dosage:		
Is child receiving/received any previous therapy?	☐ Yes	☐ No

Therapist/Therapy Center			
Services Received	☐ OT	☐ PT	☐ SPEECH
Does Your Child Receive Babies Can't Wait Services? (3 years old and under) Service Coordinator Name	☐ Yes	☐ No	
Services Received	☐ OT	☐ PT	☐ SPEECH

SCHOOL INFORMATION			
Does your child have an IEP or 504 at school?	☐ Yes	☐ No	
Services Received	☐ OT	☐ PT	☐ SPEECH

THERAPY WORKS, PC

PATIENT CONSENT FOR USE/ DISCLOSURE OF HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Parent's Name: _____

I understand that the patient's health information is private and confidential. I understand that Therapy Works, PC tries very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Therapy Works, PC may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. [* In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.]

Therapy Works, PC has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement.

Therapy Works, PC may update this "Notice of Privacy Practices". If I ask, Therapy Works, PC will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask Therapy Works, PC to limit how the patient's personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that Therapy Works, PC does not have to agree to my request. If Therapy Works, PC does agree to my request, I understand that Therapy Works, PC would follow the agreed limits.

I may cancel this consent in writing at any time by doing one of the following:

I. Signing and dating a form that Therapy Works, PC can give me called "Revocation of Consent for Use and Disclosure Of Health Care Information"; or

II. Writing, signing, and dating a letter to Therapy Works, PC. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care operations.

If I revoke this consent, Therapy Works, PC does not have to provide any further health care services to the patient.

My signature below indicates that I have been given a chance to review a current copy of Therapy Works, PC "Notice of Privacy Practices". My signature means that I agree to allow Therapy Works, PC to use and disclose the patient's personal health care information to carry out treatment, payment, and health care operations.

_____ _____ _____

Patient or legally authorized individual signature Date Time

_____

Relationship to patient
(If signed by anyone other than the patient
(Parent, legal guardian, personal representative, etc.)

Atkinson Rd Suite 1100 Lawrenceville, GA 30043
Tel. (770)995-2379 / Fax (770)995-2385
www.therapyworkspc.com

THERAPY WORKS, PC

ATTENDANCE

POLICIES AND PROCEDURES

We realize attending therapy is a huge commitment for you and your child and we want to make sure your child receives full benefit from this commitment. In order for this to occur, please note the following:

1. **It is very important that you make it to all appointments.** Consistent treatment is vital for your child's progress. Most insurances and Medicaid review billing and notes to make sure the children are attending therapy regularly and they take this into consideration when deciding if they will continue to cover therapy.
2. Your therapist is committed to your child for the therapy times you have agreed to. Do not schedule other appointments during this time. Be considerate of the therapist's time and commitment. **Notify them at least 24 hours in advance if you cannot be at therapy.** Please contact your therapist at 770-995-2379 or another number they may provide at least 24 hours before your session to cancel (exceptions- if your child wakes up sick the morning of therapy).
3. **Please be on time for your appointment to ensure a full therapy session.** Please consider traffic, weather etc. when scheduling a therapy time.
4. **If you do not come and do not call (no show) or if too many visits are missed, it will be necessary to discontinue therapy**. If your child is not at therapy, we cannot make progress so it is better to stop therapy until your child is able to consistently attend.
5. If you are going to miss 3 weeks or longer, your child will not be discharged but your scheduled time slot may be filled. We will do our best to offer you another time when you return. We often have children waiting for therapy and want to be fair to all.

Please understand these policies are for your child to have a successful experience here with us. We make every effort to make your child's needs our top priority so they can make progress. We need to work together to make this happen. Thank you so much for giving us the opportunity to work with your child.

Please contact us at 770-995-2379 if you would like to discuss your child's therapy at Therapy Works or have any questions or concerns.

Signature _____

Printed Name _____

Date _____

Patient's Name: _____

Date of Birth: _____

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To Whom It May Concern:

My child: _____,

Name

_____**Does** have an **IEP** or **IFSP** at this time.

_____**Does NOT** have an **IEP** or **IFSP** at this time due to the following reason(s):

_____My child is not enrolled in the Babies Can't Wait Program.

_____IEP is contested via due process due to disagreement with school system.

_____Child does not receive special services in the school system.

_____Child is not in the public school system.

_____Child is home schooled and receives no services through the public schools.

_____Child has been evaluated but IEP Meeting has not been held.

_____Child is waiting on evaluation. IEP Meeting has not been held.

_____Child attends a private school and does not have an IEP.

_____Child has IEP but his/her insurance does not require submission.

_____ Other_____

_____

_____

_____

_____

Parent/Guardian Signature Date

Patient's Name: _____

Date of Birth: _____

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SUBMIT

THERAPY WORKS, PC

PROVIDER SWITCH FORM

Patient's Name:_____DOB: _____

Parent/s Name:_____Phone Number:_____

Has your child received any occupational, physical or speech evaluations or treatments in the last six months?

☐ **NO** If no, please sign and date below.

☐ **YES**

If your child has received any therapy in the last 6 months (evaluation and/or treatment), please list them below:

Occupational Therapy: _____ from _____to_____.
Name of Facility Start Date End Date

Physical Therapy: _____ from _____to_____.
Name of Facility Start Date End Date

Speech Therapy: _____ from _____to_____.
Name of Facility Start Date End Date

If you wish to change therapy providers, your insurance may require the following statement:

My child will no longer be receiving therapy/therapies at the facility/facilities above and will be receiving this therapy at THERAPY WORKS, PC.

Signature _____

Printed Name _____

Date Completed:

_____

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THERAPY WORKS, PC

AUTOMATIC PAYMENT AGREEMENT

Patient's Name: _____DOB: _____

Parent/s Name: _____Phone Number:_____

Payment Information (Please circle)

Visa American Express Discover Master Card Other: _____

Debit Credit

Member Name on Card: _____

Card Number: _____ Expiration (mm/yr): _____

Security code (3 digit code off back on card): _____

Amount to Pay:

- ☐ Amount Owed at this time
- ☐ $___ each month – payment plan options available but have to be approved by Therapy Works
- ☐ Pay co-payment of $_____ per visit

Schedule:

- ☐ Weekly
- ☐ Bimonthly
- ☐ Monthly (to be processed at ___ day of the month)

Email Receipt to: _____

I hereby authorize Therapy Works to withdraw funds from my account for payment of therapy services as per the above agreement. I also authorize Therapy Works to charge any outstanding balance that is owed at the culmination of my child's therapy services.

Signature Printed Name

_____ _____

Date

_____

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