Ducktails Pediatric Therapy

568 Blue Ridge Drive • Evans, Ga. 30809

Patient Information

Date_____

Last Name: _____First Name: _____DOB: _____ M F

Address: _____

City_____ST_____Zip_____

Please make sure to put the email address you would like appointment reminders to go to.

Phone: _____ Work: _____ Cell: _____

Email: _____

Father: Last Name:_____ First Name_____ DOB _____ SS#_____

Mother: Last Name:_____ First Name: _____ DOB_____ SS# _____

Physician: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____Policy Number: _____

Insured Name:: _____ Insured SS# _____ DOB: _____

ID#:_____ Group#:_____

Relationship to Patient: _____ Employer/Work#_____

Secondary Insurance: _____ Policy Number: _____

Insured's Name: _____Insured's SS# _____DOB _____

Relationship to Patient: _____ Employer/Work#_____

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CONSENT FOR RELEASE OF MEDICAL RECORD

I _____ the parent/legal guardian of _____ voluntarily and freely give my consent for release of my child's medical records to Ducktails, Inc. I have had an opportunity to ask questions and receive information regarding the purpose of this release and the use of the medical records. I understand that this release may be withdrawn at any time. I also understand that these records are confidential.

Signature of parent/legal guardian _____

Witness _____

Below please list anyone that is able to have access to your child's information/records

_____. _____.

_____. _____.

_____. _____.

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Effective January 1, 2016

CANCELLATION/ATTENDANCE POLICY

We understand that there are occasions when you must miss appointments due to work or family situations. Please provide us with 24 hours when an appointment needs to be cancelled.

ANY MISSED APPOINTMENT WITHOUT 24 HOURS NOTICE OF CANELLATION WILL RESULT INA $25 FEE THAT IS NOT COVERED BY INSURANCE. PAYMENT MUST BE COLLECTED PRIOR TO THE NEXT APPOINTMENT.

Effective therapy requires consistent appointment attendance. All patients are *required* to attend *85%* of appointments or they will be moved to the cancellation list. In order to be placed back on the regular appointment schedule, you will have to be consistent for a minimum of 3 visits. This ensures that we at Ducktails will be able to provide a high level of care for all of our scheduled patients. WE APPRECIATE YOUR COOPERATION IN THIS MATTER AND WE HOPE TO CONTINUE PROVIDING SUCCESSFUL TREATMENT TO OUR PATIENTS. THANK YOU!

I have read and understand Ducktails, Inc. cancellation policy. I understand that I may call and leave a message after business hours if necessary.

_____ _____

Signature of Parent or Guardian Date

_____ _____

Witness Date

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Notice of Privacy Rights and Practices

This Notice of Privacy Rights and Practices serves as the notice required by law to be proceeded to you and describes how your health information may be protected and disclosed in order to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. This notice also describes how you can access and control your past, present, and future physical or mental health or condition, related health care services, or your past, present, or future payment for healthcare.

The law requires that I protect the privacy of protected health information, and to provide you with a copy of this Notice, which describes my legal duties and privacy practices with respect to protected health information. I may change any of the privacy practices set forth in the Notice at any time with a New Notice. I am required to abide by the terms of this Notice until a New Notice becomes effective. The New Notice will be effective for all protected health information that I maintain as of the effective date of such New Notice's effective date.
You may request a copy at any time.

Summary Information

Uses and Disclosures of Health Information

I use and disclose your health information about you for treatment, payment, and healthcare operations
Treatment: I may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: I may use or disclose medical information about you so that the treatment and services you received may be billed to and payment may be collected from you, and insurance company, or a third party. I may also use and disclose medical information about you to obtain prior approval or to determine whether you are insurance will cover treatment.
Healthcare Operations: I may use and disclose your health information in connections with our healthcare operations. Healthcare operations include quality access and many improvement activities; such as, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conduction of training programs for healthcare professionals, accreditation, certification, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give written authorization to use or disclose your information to anyone for any purpose. If you give me an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, I cannot use or disclose your health information for any reason except those described in this notice.

*Effective April 13th, 2003 a new federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA) went into effect

Right to Amend: You have the right to request that I amend your health information. (Your request must be in writing and it must explain why the information should be amended.) I may deny your request under certain circumstances.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice at any time. To obtain a paper copy of this notice, please request on in writing from the contact information listed at the end of this Notice.

Questions and Concerns

If you have any questions or concerns regarding this notice or Ducktails Pediatric Therapy's privacy policies, please contact me at:

Office (706) 364-5262
Fax (706) 364-5263
568 Blue Ridge Drive
Evans, GA 30809

If you are concerned that I have violated your privacy rights, or you disagree with a decision that I made about access to your health information or in response to a request you made or restrict the use or disclosure of your health information or to have me communicate either you by alternative means or an alternative location, you may contact me using the information listed above. You may also submit a written complaint to the U.S. department of Health and Human services.

I have received the Notice of Privacy Practices and I have had the opportunity to review it.

Patient Name:_____Patient DOB:_____.

Parent Name:_____Parent Signature:_____.

Today's Date: _____

Witness: _____

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Toilet Training Policy

If your child is not toilet trained, you **MUST** remain in the immediate vicinity throughout your child's therapy session to be available to address any toileting needs.

Tardy Policy

If you are not on time for your therapy session, the therapist reserves the right not to treat your child that day. You must be here on time to pick your child up at the end of the therapy session.

Signature : _____ Date _____.

Witness: _____Date_____.

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PLEASE READ AND SIGN THE FOLLOWING CONCERNING OUR OFFICE POLICIES AND ASSIGNMENT OF ISURANCE BENEFITS:

Payment is expected at time of visit unless prior arrangements have been made. All copays coinsurance and deductibles must be paid at time of service.

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of my dependents. I further expressly agree and acknowledge that my signature on this document authorizes any therapist at Ducktails Pediatric Therapy and Wellness, Inc. to submit claims for benefits for services rendered or for services to be rendered, without obtaining my signature on each claim to be submitted for my dependents and that I am bound by this signature as though the undersigned had personally signed the particular claim.

I, _____ hereby authorize _____
(Name of Insurance Company)

to pay and hereby assign directly to Ducktails Pediatric Therapy and Wellness, Inc. all benefits, if any, otherwise payable to me for services as described on the attached forms. *I understand that I am financially responsible for all charges incurred.* I further acknowledge that any insurance benefits when received by and paid to Ducktails Pediatric Therapy and Wellness, Inc will be credited to my account in accordance with the above assignment.

_____ _____
(Authorized signature of Insured) (Date)

I, _____, attest that the following insurer, _____
(Name of Insurance Company)

is the primary medical insurance carrier for , _____. Furthermore, there is
(Name of child)

no other medical insurer responsible for payment of services rendered. I hereby give my consent for the examination and treatment of the above name patient. I certify that I am a legal guardian or have been authorized by a legal guardian of the above named patient to consent for examination and treatment I am aware that payment remains my personal responsibility regardless of insurance or other third party involvement (including court orders). ***I understand that if at any time a claim is not paid or a refund is requested for having another primary insurance, I am responsible for the fees incurred.***

_____ _____ _____
(Signature required for treatment) (Relationship to Patient) (Date)

_____ _____
(Witness) (Date)