

Today's Date: _____ ANNUAL PAPERWORK UPDATE



**** Please let staff know if you have any questions. ****

Child's Full Name: _____ DOB: _____

Diagnosis: _____

Referring Physician Practice Name: _____

Referring Physician Name: _____ Physician Phone: _____

Pediatrician (if different from referring): _____

Parent/Caregiver Name #1: _____ Occupation: _____

Biological: _____ Adoptive: _____ Adoption Date: _____

Home Address: _____

City: _____ State: _____ Zip code _____

Home Phone #: _____ Work #: _____ Cell #: _____

Email: _____

Emergency contact: _____ Best contact # _____

Who lives in the home (Please add siblings and ages for family services):

How may we reach you? Please check all that apply.

Text Voicemail Email

List all INDIVIDUALS who may accompany your child for treatment and/or receive medical information (other than legal guardians already listed on account and medical record). Please include name, number and relationship to the patient.

NAME:	Relationship:	Contact #:
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that any person who is not a legal guardian of my child or whose name does not appear on the above list will not be given access to any medical information or be allowed to accompany my child for treatment without further written permission.

Please list any other PROFESSIONALS who we may share your child's medical information with. This includes TTP receiving information from professionals or providing information to professionals.

NAME:	Practice:
_____	_____
_____	_____

School/Family/Behavioral Changes:

CHANGES IN MEDICAL HISTORY

Describe any significant changes in medical history within the last year.(specialists, medications, surgeries, new diagnoses):

Does your child use any medical equipment/aides currently? (Communication device, wheelchair, braces, etc.)

Please list any food or environmental allergies your child may have:

Does your child have seizures? Yes No If yes, please ask the front office for a Seizure Action Plan form.

If you would like to make any changes to your child’s current Media Release, please let the front office know.

The Privacy Practices and The Attendance Policy are posted in the lobby and copies are available upon request. By signing this form, I agree to all the terms listed in the Privacy Practices and the Attendance Policy.

We require that a parent/guardian remain in the building during therapies (other than Bridges or TheraSuit). Should an emergency occur, and you are not in the building, we will contact 911 and the child will be transported to the Palmetto Health Children’s Hospital. A staff member will accompany your child until a parent or guardian arrives. The parents/caregivers we have listed will be notified immediately.

AUTHORIZATION AND CONSENT TO TREAT A MINOR

The undersigned does hereby authorize The Therapy Place consent to exam and treat the below mentioned minor by employees of The Therapy Place without a Parent or Guardian present.

Parent/Guardian Signature

Date

Child's Name/ DOB

Relationship to Child

INSURANCE

Name of Primary Insurance: _____

Primary Insured's Name: _____ Primary Insured's DOB: _____

Policy #: _____

Circle Type of Medicaid: **Medicaid FFS/TEFRA** **BlueChoice** Medicaid Policy #: _____

The Therapy Place will need to scan **ALL** of your child's insurance cards every year. Please remember to bring them to your next appointment. If you have BLUECHOICE, then you should have two (2) different insurance cards. Thank you!

ASSIGNMENT OF INSURANCE BENEFITS

CHILD'S NAME: _____

PRIMARY INSURANCE NAME: _____

SECONDARY INSURANCE NAME: _____

By signing the form below, I am allowing The Therapy Place to submit claims on my child's behalf and receive payment for services rendered to my child.

1. I understand that signing this form authorizes The Therapy Place to submit claims on my (or my child's) behalf directly to Medicaid or my private health insurance provider. The Therapy Place will accept assignment of these benefits.
2. I also understand that signing this form authorizes the release of medical or other information to my health insurance providers and The Therapy Place as necessary to complete the billing process.

Signature

Date

Printed Name

Relationship to Child

Patient Billing Contract
FOR THOSE WITH PRIVATE INSURANCE AND MEDICAID

I, _____ (name of responsible party - parent/guardian) understand that The

Therapy Place Inc. does not participate with my child's primary insurance.

_____ (initials) I understand that to file my child's claims to his/her secondary Medicaid, The Therapy Place Inc. MUST have the processing information (EOB) and payment (if applicable) from the primary insurance carrier. Because The Therapy Place does not participate with my child's primary carrier, I understand that my child's primary insurance carrier may send all processing information and/or payments (checks) *directly to me* instead of to The Therapy Place Inc.

_____ (initials) I understand that I am required to bring in each Explanation of Benefits and each check payment from my primary insurance carrier to The Therapy Place **within 30 days of the date on the EOB and/or check.**

_____ (initials) I understand that if I fail to do this on a regular basis and within the time allotted, The Therapy Place Inc. will have no choice but to stop providing services to my child, as they will be unable to obtain payment for services from my child's Medicaid.

_____ (initials) I understand that if I have any questions about this process and require any assistance regarding this contract, I can contact the Billing Manager, Teresa Fleming, at 803-546-0567 or tfleming@thetherapyplace.org and/or speak to Brooke Proctor during office hours.

Please provide email address for monthly email reminders: _____

By signing below, I acknowledge the terms of the above billing contract. I understand that payments made to me on behalf of services rendered by The Therapy Place may be surrendered to TTP directly (by signing the back) OR I will deposit checks and make payment directly.

Signature of Legal Guardian/Responsible party

Date

Please print name of person signing

Relationship to child