Sumlar Therapy Services, Inc.

193 Sam Lisenby Road Ozark, AL 36360 (334) 445-6336

Patient Information (Page One)

Date_____

Patient's Name _____
DOB_____SSN_____
Phone_____
Patient's Street Address_____
City, State, Zip_____

Patient's Diagnosis _____
Patient's Primary Doctors_____

Parents' Names_____
If different from above:
Parents' Street Address_____
City, State, Zip_____
Phone (mother) (home)_____ (work)_____ (cell)_____
Phone (father) (home)_____ (work)_____ (cell)_____
Other Points of Contact_____

Physician Referral

Name of Referring Physician _____
Name of Practice_____
Address_____
Phone_____

You must have a prescription for therapy from above physician. If you have Medicaid, the referral must be on the appropriate Medicaid Referral form. **An evaluation cannot be performed if we do not have this prescription.** Please have the prescription faxed to this office, call to make sure we have received it, and/or bring an original or copy with you to your first appointment.

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Patient Information (Page Two)

Primary Insurance

Name of Primary Insured _____DOB_____
SSN_____ Relationship to Patient_____
If different from above:
Phone (home)_____ (work)_____ (cell)_____
Street Address_____
City, State, Zip_____
Employer _____
Employer's Address_____

Name of Insurance Company _____
Address_____
Phone Numbers_____
Group Number _____ Policy Number _____
Contact Person _____

Secondary Insurance

Name of Secondary Insured _____DOB_____
SSN_____ Relationship to Patient_____
If different from above:
Phone (home)_____ (work)_____ (cell)_____
Street Address_____
City, State, Zip_____
Employer _____
Employer's Address_____

Name of Insurance Company _____
Address_____
Phone Numbers_____
Group Number _____ Policy Number _____
Contact Person _____

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AUTHORIZATION FOR TREATMENT/ASSIGNMENT OF BENEFITS/PAYMENT RESPONSIBILITY AND RELEASE OF INFORMATION

Patient Name:

_____

Address: _____

Provider: Sumlar Therapy Services, Inc.

Authorization for Treatment: The undersigned hereby authorizes Sumlar Therapy Services, Inc. and any of their contractors (collectively referred to as "Provider") to render to patient physical therapy, occupational therapy, or speech therapy or other related services (collectively referred to as "Therapy Services") that Provider and/or patient's physician determine to be necessary and advisable. The undersigned agree to cooperate with all reasonable requests of the Provider in connection with Provider's rendering of Therapy Services.

Assignment of Benefits: The undersigned hereby assign and transfer to provider the right to all third party payments (including Medicaid, and/or private insurance benefits) to which the undersigned may be or become entitled to for Therapy services rendered by the provider. The undersigned hereby authorizes Provider to apply and file for all such benefit payments on behalf of the patient and direct that such payments be made directly to the Provider. Any insurance benefit payments received by the undersigned for services rendered by the provider shall be paid to the provider.

Payment Responsibility: The patient shall be financially responsible for any portion of the provider's invoice that is not paid, except for payments denied by Medicaid or in the event of covered services provided to Medicaid recipients. The undersigned agrees to execute any and all documents and perform any acts that Provider may reasonably request to ensure that all third party benefits for Therapy services are paid to provider.

Release of Information: The undersigned hereby certifies that all information provided to Provider by the undersigned is true and accurate in all respects. The undersigned hereby authorizes Provider to disclose any information, medical and non-medical, furnished to or obtained by Provider in connection with patient's diagnosis and/or treatment, to any physician, government agency (including the U.S. Department of Health and Human Services, or any of its intermediaries or carriers), insurance company or health care provider requesting such information. The undersigned agrees to allow Provider access to patient medical records and agrees to allow provider to make copies of such records. The undersigned consents to the discussing by Provider of the patient's medical condition with patient's family members for medical or claims management purposes.

Executed this _____ day of _____, 20____.

_____

Patient's or Responsible Party's signature

_____

Witness (Agency Representative)

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CLINIC GUIDELINES

Therapy Sessions

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- Your appointments will be scheduled on a consistent day and time each week for your convenience.
- Hippotherapy (therapy on horseback) or aquatic therapy (therapy in the pool) will be scheduled in some sessions as determined by the therapist's goals and treatment plan.
- Frequency of therapy sessions my range from once per month to three times per week.

Cancellation Policy

- **At least 24 hours notice is required to cancel an appointment.** Lesser notice is only acceptable in circumstances of sudden illness or emergency.
- **Sumlar Therapy reserves the right to discharge any patient after three (3) "no shows" for therapy.** A "no show" is when an appointment is not kept and the parent has not called within a timely manner to cancel the appointment.
- **Frequent absences without excuse** are not acceptable and may result in discharge from therapy.
- **Therapy will not be cancelled due to inclement weather (too hot, too cold, rainy).** When therapy outdoors is not advisable due to weather conditions, therapy sessions will continue as scheduled in the clinic. In the case of dangerous weather conditions, however, when travel is not advisable (tornado warning, hurricane, etc.), therapy will be cancelled. Please call the clinic.

Payment Policy

- **Payment is due in full upon receipt of bill**, unless payment arrangements have been made. Nonpayment may result in the patient's discharge from the program.
- **Co-payments are due at each scheduled session.**
- **Patients choosing to pay privately** (i.e., no insurance coverage) will be required to pay prior to each session.

I have read the above guidelines and agree to follow the terms of these policies.

_____

(Responsible Party) (Date)

These guidelines were revised August 1, 2008 and replace any and all previous versions. Thank you.

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CONSENT FORMS

Patient's Name: _____ DOB:_____

VIDEOGRAPHY/PHOTOGRAPHY/WEBSITE

I hereby give my consent for any videography or photography for purposes of recording the patient's functional status for medical records or for commercial use.

_____ _____
Signature of Parent or Guardian Date

I hereby give my consent specifically to allow my child's photograph to be posted on the corporation's website, sumlartherapy.com, and for my child's first name to be used in association with the picture.

_____ _____
Signature of Parent or Guardian Date

REQUEST FOR INFORMATION

I hereby give my consent to any physician, hospital, school, or clinic to release the information requested concerning the diagnosis and/or treatment of the client named below, to Sumlar Therapy Services.

This information will be utilized in determining the most appropriate diagnostic and treatment procedures for the below named client and will be treated as confidential.

_____ _____
Signature of Parent of Guardian Date

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EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Sumlar Therapy Services, its officers, employees, and/or representative to:

1. Secure and retain medical treatment and transportation if needed.

2. Release any records upon request to the authorized individual or agency involved in the medical emergency treatment.

Patient's Name: _____DOB:_____

Physician's Name: _____ Phone: _____

Please describe any medical conditions that may require special precautions or treatment and any medications the patient is now taking:

_____
_____
_____

List any allergies to medications the patient might have.

_____

Person(s) to Contact	Phone Number(s) --Include cell phones
_____	_____
_____	_____
_____	_____

_____ _____
Signature Date

_____
Relationship to Patient

Sumlar Therapy Services, Inc.

193 Sam Lisenby Road Ozark, AL 36360 (334) 445-6336

Notice of Privacy Practices

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. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

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 make the changes in our privacy practices and the new terms of 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 for 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 treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operation: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, 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 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 affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient 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 healthcare or with payment for your healthcare, 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, of 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 to such uses or disclosures. In the event of your incapacity 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 healthcare.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or 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 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 information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information or inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

_____

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice.)

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 than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for 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).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or 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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

_____

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 you disagree with a decision we made about 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 have 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.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201.

Contact Officer: Kristin R. Sumlar
Telephone: (334)445-6336
Address: 2428 Stuart Tarter Road, Ozark, AL 36360

I have received and reviewed a copy of this Notice of Privacy Practices Summary.

_____

(signature) (date)

Sumlar Therapy Services, Inc.

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Notice of Privacy Practices

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Contact Officer: Kristin R. Sumlar
Telephone: (334)445-6336
Address: 2428 Stuart Tarter Road, Ozark, AL 36360

Patient's Copy--Please keep this for your records.

Sumlar Therapy Services, Inc.

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CLINIC GUIDELINES

Therapy Sessions

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- **Therapy will not be cancelled due to inclement weather (too hot, too cold, rainy).** When therapy outdoors is not advisable due to weather conditions, therapy sessions will continue as scheduled in the clinic. In the case of dangerous weather conditions, however, when travel is not advisable (tornado warning, hurricane, etc.), therapy will be cancelled. Please call the clinic.

Payment Policy

- **Payment is due in full upon receipt of bill**, unless payment arrangements have been made. Nonpayment may result in the patient's discharge from the program.
- **Co-payments are due at each scheduled session.**
- **Patients choosing to pay privately** (i.e., no insurance coverage) will be required to pay prior to each session.

This copy is for your records. Do not turn this page into STS.

These guidelines were revised August 1, 2008 and replace any and all previous versions. Thank you.

Sumlar Therapy Services, Inc.

193 Sam Lisenby Rd Ozark, AL 36360 (334) 445-6336

Directions

The clinic is right off of Highway 231 on Sam Lisenby Road. There are handicap parking spaces for those who need them for loading and unloading. Please drive very slowly and watch carefully for children.

From Dothan
The clinic is approximately 30 minutes from Wiregrass Commons Mall. Leave Dothan on Hwy 231 North. Approximately 21 miles north of Dothan is a stoplight at County Road 36 (Roy Parker Road). You'll see a DMC Surgery Center on your right, proceed exactly .5 miles north on 231. **This is the 2nd turn lane to the left, turn left on Sam Lisenby Road. Take the private road to your left and proceed into our parking lot.**

From Troy
The clinic is approximately 20 minutes south of Troy. Take 231 South toward Ozark. You'll see Garcia's Furniture & Appliance Store on your right with "Whirlpool" in big letters on the building and it's kind of in the hollow. **Go to the top of the hill .3 miles and turn right on Sam Lisenby Road**. **Turn left on the private road and proceed into our parking lot.**

From Fort Rucker
The clinic is approximately 20 minutes from Fort Rucker. **Leave Fort Rucker through the Ozark gate, on Andrews Avenue. Continue on Andrews Avenue, turn left on Highway 231. At your next traffic light, the intersection at Highway 231 and Roy Parker Road (County Road 36 – this is where the DMC Surgery Center is located on your right), travel .5 miles. Take the 2nd left turn lane and turn left on to Sam Lisenby Road. Take the private road to your left and proceed into our parking lot.**

From Enterprise
The clinic is approximately 30 minutes from Enterprise. **Leave Enterprise on Highway 27**, **heading toward Ozark**. **At the intersection of Highway 231, take a left, heading north. At the first light, you will see County Road 36** (Roy Parker Road, at the Dale Medical Outpatient Surgery Center). **Continue on 231 for a distance of .5 miles**. **Take the 2nd left turn lane and turn left on to Sam Lisenby Road. Take the private road to your left and proceed into our parking lot.**

From Abbeville
The clinic is approximately 30 minutes from Abbeville. **Leave Abbeville on Highway 27**, **heading toward Ozark**. Shortly after passing through Ewell (Dykes Grocery and Wille J's is on the right), **take a right on County Road 39** (Stuart Tarter Road) at the City Body and Fender Shop. You will also see a sign for Vivian B. Adams School. Follow County Road 39 (It's Stuart Tarter Road, but changes to Roy Parker Rd and County Road 36) all the way to Highway 231. **Turn right on Highway 231 and go 0.5 miles, and turn left onto Sam Lisenby Road. Take the private road to your left and proceed into our parking lot.**