Sumlar Therapy Services, Inc.

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

Patient Information (Page One)

(Please Print)

Date: _____

Patient's Name: _____
First Middle Last

Nick Name/Preferred Name_____

Male _____ Female_____ Date of Birth:_____SSN:_____

Patient's Street Address_____

City_____State:_____Zip:_____

Home Phone:_____ Cell Phone: _____Work Phone:_____

Mother's Name _____

Mother's Address: (if different from above)_____

City:_____State:_____Zip:_____

Mom's Home Phone: _____Cell Phone:_____Work Phone:_____

Email Address: _____

Father's Name_____

Father's Address: (if different from above) _____

City:_____State:_____Zip:_____

Dad's Home Phone:_____Cell Phone:_____Work Phone:_____

Email Address: _____

Emergency Contact:

_____
Name Relationship Phone

_____
Name Relationship Phone

_____
Name Relationship Phone

Pediatrician Referral

Name of Referring Pediatrician_____

Name of Practice: _____

Office Location:_____

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_____M or F_____

If different from above:

Phone (home) _____ (cell)_____(work)_____

Street Address: _____

City_____State_____Zip_____

Employer_____

Employer's Address_____

Name of Insurance Company_____

Address_____

Phone Numbers_____

Policy Number_____Group Number_____

Contact Person_____

Secondary Insurance

Name of Primary Insured: _____DOB:_____

SSN_____Relationship to Patient_____M or F_____

If different from above:

Phone (home) _____ (cell) _____ (work)_____

Street Address: _____

City_____State_____-Zip_____

Employer_____

Employer's Address_____

Name of Insurance Company_____

Address_____

Phone Numbers_____

Policy Number_____Group Number_____

Contact Person_____

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

Patient Name: _____Date of Birth: _____

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 by the undersigned is true and accurate in all respects. The undersigned hereby authorizes the Provider to disclose and 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 or 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.

Notice of Privacy Polices Acknowledgment: This Notice of Privacy Practices ("Privacy Notice") provides information about how Sumlar Therapy Services, Inc., will use, release, and disclose my protected health information for treatment, payment and health care operations without the need for any additional or specific authorization. I acknowledge that I have received a copy of the Notice of Privacy Practices for Sumlar Therapy Services, Inc.

Executed this _____day of _____, 20___

_____

Patient's or Responsible Party's signature

_____

Witness (Agency Representative)

Sumlar Therapy Services, Inc.

Pediatric Physical Therapy, Occupational Therapy, and Speech Therapy
With Hippotherapy and Aquatic Therapy
193 Sam Lisenby Road - Ozark, AL 36360 - Phone (334) 445-6336 - Fax (334) 445-6363
email@sumlartherapy.com www.sumlartherapy.com

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 website and/or social media 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 above, to Sumlar Therapy Services, Inc.

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

_____ _____
Signature of Parent or 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, Inc., its officers, employees, and/or representatives to:

1. Secure and retain medical treatment and transportation is 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.

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CLINIC GUIDELINES

Therapy Sessions

- Some children come for 30 minutes of therapy per week, while others come for 90 minutes of Speech, PT, and OT twice per week, dependent upon the child's needs, the clinic schedule, and the parent's schedule. Parents or guardians may **NOT** leave the premises during their child's therapy session.
- We reserve an appointment for your child every week on the same day at the same time. Please plan to schedule other appointments around your therapy.
- Hippotherapy (therapy on horseback) or aquatic therapy (therapy in the pool) are two of our unique modes of treatment in PT, OT, and Speech, in addition to the traditional model in a private treatment room or sensory gym. Therapists determine how to best address the goals set for each child and which mode of treatment may be beneficial.
- When therapy outdoors is not advisable due to weather or safety issues, therapy sessions will continue as scheduled in the clinic. Therapy will not be canceled.

Cancellation Policy

- **If you cannot come to an appointment, you need to cancel in advance.**
- **If your child is sick, please cancel your appointment.** We do not treat children with illnesses in the clinic.
- **If you miss appointment(s) and fail to communicate with the clinic, your child will be removed from the schedule and discharged from therapy.**
- **In the case of dangerous weather conditions the clinic may close.** We will communicate this to you via our **Facebook** page. Another way we communicate this is to follow Ozark City Schools' decisions regarding inclement weather closures; if OCS closes early or doesn't open due to dangerous weather conditions we will do the same.

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 therapy.
- **Co-Payments are due at each scheduled session.**
- **Patients choosing to pay privately** (i.e. no insurance coverage or having an insurance that we do not accept) **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 February 15, 2018 and replace any and all previous versions. Thank you.