



Sumlar Therapy Services, Inc.

Pediatric Physical Therapy, Occupational Therapy, and Speech Therapy
With Hippotherapy and Aquatic Therapy

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www.sumlartherapy.com

A parent or guardian must complete this packet. Once completed, please bring or email it to the clinic along with the patient's insurance/Medicaid card and a parent/guardian's valid photo I.D.

Patient Information

First Name _____
Middle _____
Last Name _____
Address _____
City _____
State _____ ZIP Code _____
DOB _____ Gender _____
School _____

Parent/Legal Guardian Contact

Name _____
Relationship _____
Address _____
City _____
State _____ Zip Code _____
Cell _____
Home _____ Work _____
Email Address _____

Secondary Contact

Name _____
Relationship _____
Address _____
City _____
State _____ Zip Code _____
Cell _____
Home _____ Work _____
Email Address _____

Other Contact

Name _____
Relationship _____
Address _____
City _____
State _____ Zip Code _____
Cell _____
Home _____ Work _____
Email Address _____

Pediatrician Referral

Name of Referring Pediatrician _____ Phone _____
Name of Practice _____
Office Location _____

The patient must have a prescription/referral from a pediatrician on file in this clinic prior to initiation of services.

Insurance Information

Primary

Insurance Company _____

Policy Holder _____

Relationship _____

DOB _____

SSN _____

Address _____

City _____

State _____ Zip Code _____

Phone Number _____

Contract Number _____

Group Number _____

Secondary

Insurance Company _____

Policy Holder _____

Relationship _____

DOB _____

SSN _____

Address _____

City _____

State _____ Zip Code _____

Phone Number _____

Contract Number _____

Group Number _____

Other

Insurance Company _____

Policy Holder _____

Relationship _____

DOB _____

SSN _____

Address _____

City _____

State _____ Zip Code _____

Phone Number _____

Contract Number _____

Group Number _____

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

Authorization for Treatment: I authorize Sumlar Therapy Services, Inc. (collectively referred to as "Provider") to provide the patient physical therapy, occupational therapy, speech therapy, or other related services (collectively referred to as "Therapy Services") that Provider and the patient's physician determine to be necessary and advisable. I agree to cooperate with all reasonable requests of the Provider in connection with Provider's rendering of Therapy Services.

Assignment of Benefits: I assign and transfer to Provider the right to all third party payments (including Medicaid, and/or private insurance benefits) for Therapy Services rendered by the Provider to which I may be/become entitled to. I authorize 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 that I receive for services rendered by the Provider shall be paid to the Provider.

Payment Responsibility: I assume the financial responsibility for any allowable charges not paid by the patient's insurance. I agree 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: I certify that all information that has been provided is true and accurate in all respects. I authorize the 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. I agree to allow Provider access to patient medical records and agree to allow Provider to make copies of such records. I consent to the discussing by Provider of the patient's medical condition with patient's family members for medical or claim(s) management purposes.

Request for Information: I consent to any physician, hospital, school, or clinic to release the information requested concerning the diagnosis and/or treatment of the patient to Sumlar Therapy Services, Inc. This information will be utilized in determining the most appropriate diagnostic and treatment procedures for the patient named above and will be treated as confidential.

Acknowledgment of Receipt of Notice of Privacy Practices: This Notice of Privacy Practices provides information about how Sumlar Therapy Services, Inc. will use, release, and disclose the patient's protected health information. I acknowledge that I have received a copy of the Notice of Privacy Practices for Sumlar Therapy Services, Inc. and I understand that I may contact the person named in the Notice if I have any questions about the content of the Notice.

I confirm I am the parent or legal guardian of _____, DOB: _____.

Parent or Guardian Signature

Date

Consent Forms

Patient's Name: _____

DOB: _____

Please read each section completely and **INITIAL** on the line provided to indicate your decision. Sign below.

INITIAL

_____ I give my consent for any **VIDEOGRAPHY OR PHOTOGRAPHY** for purposes of recording the patient's functional status for medical records and/or therapist training while maintaining patient privacy.

_____ I give my consent to allow the patient's **photograph(s) and/or video(s)** to be posted on the corporation website and/or social media and for the patient's first name to be used in association with the picture.

or

_____ I **DO NOT** give my consent for any **VIDEOGRAPHY OR PHOTOGRAPHY**.

INITIAL

_____ I approve the patient to participate in **HIPPOTHERAPY** (therapy on a horse), if recommended by a therapist. I have advised or will advise the therapist of any specialized needs or concerns based on physical limitations or medical status. To my knowledge, there is no reason why the patient cannot participate in supervised equine activities; however, I understand that the treating therapist will make the decision regarding the use of hippotherapy during a therapy session.

or

_____ I **DO NOT** approve the patient to participate in **HIPPOTHERAPY**.

INITIAL

_____ I approve the patient to participate in **AQUATIC THERAPY** (therapy in a pool), if recommended by a therapist. I have advised or will advise the therapist of any specialized needs or concerns based on physical limitations or medical status. To my knowledge, there is no reason why the patient cannot participate in supervised aquatic activities; however, I understand that the treating therapist will make the decision regarding the use of aquatic therapy during a therapy session.

or

_____ I **DO NOT** approve the patient to participate in **AQUATIC THERAPY**.

Parent or Guardian Signature

Date

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 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

Parent or Guardian signature

Date

Relationship to Patient

CLINIC GUIDELINES

GENERAL INFORMATION

- ❖ Physical Therapy (PT), Occupational Therapy (OT), and/or Speech Therapy (ST) may be recommended for your child by your pediatrician and our therapists.
- ❖ Some patients come for therapy as little as 30 minutes once per week, while others may come a longer duration multiple times per week. *Therapy and frequency of therapy depend upon the patient's needs, the clinic schedule, and the parent's schedule.*
- ❖ In addition to a traditional model of therapy which is provided in a private treatment room or sensory gym, we offer aquatic therapy and hippotherapy as two of our unique methods of treatment in PT, OT, and Speech. Therapists determine how to best address the goals set for each patient, and which method of treatment may be beneficial. If the patient is receiving therapy outside for any of their sessions, and inclement weather occurs, please remember that therapy will continue inside uninterrupted.
- ❖ To achieve maximum progress, consistent attendance is considered imperative.
- ❖ Information about Sumlar Therapy events, special hours, and closings may be posted on the **Sumlar Therapy Facebook** page. Please follow us and refer often to this page so that you can stay informed.

Please carefully read and initial each following item. If you have any questions, please ask a staff member for clarification.

GENERAL POLICIES

Parent/Guardian: Please read and *initial* each section.

_____ If the patient is receiving therapy outside for any of their sessions (i.e, pool, arena), and inclement weather occurs, please remember that therapy will continue inside uninterrupted. Please be prepared. Therapy will NOT be canceled UNLESS there are dangerous weather conditions that interfere with safety. We will communicate any decision to close the clinic via our Sumlar Therapy Facebook page.

_____ We reserve an appointment for the patient every week on the same day at the same time. If you must cancel an appointment for any reason, please try to schedule a make-up session during the same week or month of the missed appointment.

_____ Parent/Guardian MUST REMAIN on the premises during the child's therapy session.

_____ Parents/Guardians/Others in attendance whose behavior, attire, condition, or temperance is considered by administration to be disruptive or potentially harmful to others will be asked to leave and may result in the patient's discharge from the clinic. Issues of a serious or illegal nature affecting the safety of a child will be reported to the Department of Human Resources. Please be respectful of others.

ATTENDANCE POLICY

Parent/Guardian: Please read and *initial* each section.

_____ If you are unable to attend an appointment **you must cancel prior to the appointment time**. During or after clinic hours, please **leave a voice message** (speak clearly) or **email receptionist@sumlartherapy.com** to notify us of a cancellation (include the patient's full name, date of birth, appointment time, and reason for cancelling). We check messages every morning and throughout the day. If you do not attend your appointment and have not let our office know that you will be unable to attend an appointment BEFORE the appointment time it will be considered an **unexcused absence**.

_____ Excused absences may include:

- **Sickness:** Children with a fever or any contagious illness should not be brought to the clinic. Please see our policy below regarding illness and attendance.
- **Doctor appointments:** Whenever possible, please schedule local doctor appointments at a time other than your regularly scheduled therapy time.
- **Family emergency or unexpected transportation problems**

_____ POOR ATTENDANCE will result in DISCHARGE: **THREE UNEXCUSED ABSENCES** may result in discharge from therapy. Excessive absences, excused or unexcused, may also result in discharge from therapy. Decisions regarding discharge will be made at the discretion of a clinic administrator. The parent/guardian and the patient's pediatrician will be notified that the patient has been removed from the clinic schedule.

_____ READMISSION FOLLOWING POOR ATTENDANCE: If a patient is discharged due to POOR ATTENDANCE once, the parent/guardian may request a new therapy referral from the pediatrician to return to Sumlar Therapy following a minimum of a SIX MONTH period. During this episode of care, **ONE UNEXCUSED ABSENCE**, or any poor attendance as denoted above, may result in **discharge from the clinic**. Any patient discharged twice for poor attendance will **not be readmitted** to the clinic. The parent/guardian and the patient's pediatrician will be notified that the patient has been permanently discharged from the clinic.

SICK POLICY

Parent/Guardian: Please read and *initial* each section.

_____ For the wellbeing of the families we serve, please do not bring the patient to therapy if he/she has any of the following conditions or symptoms. There are times when it is appropriate to cancel your appointment if **ANYONE in the household** has these **contagious** conditions or symptoms.

- Fever
- Excessive cough or discharge from nose or eyes
- Pink eye, suspected or confirmed
- Unidentified rash
- Lice
- Vomiting
- Diarrhea
- Contagious skin conditions such as ringworm
- Child was kept out of school that day due to illness, or school called for child to be picked up due to suspected or confirmed illness

_____ Administration may ask you to leave if the patient or anyone in attendance arrive to the clinic with any illness, symptoms, or condition that may be considered to be contagious to others.

_____ Usually, patients may return to therapy once they or the household have been **symptom-free for 24 hours without using fever-reducing medication**. However, in some instances, the patient might require a doctor's note to return to therapy if he/she has a serious contagious illness or injury. If you have questions regarding when to return to therapy, please call the clinic.

PAYMENT POLICY

Parent/Guardian: Please read and *initial* each section.

_____ 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 prior to 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.

Parent or Guardian signature

Date