PATIENT REGISTRATION

Last Name First Middle Age

Address City State Zip

Birthdate ______ Sex ______ SSN ______ email ______

Home Phone ______ Work Phone ______ Cell Phone ______

*** PLEASE STAR PREFERRED TELEPHONE NUMBER TO CONFIRM APPTS. ***

Referring Physician(s): ______ Phone Number ______

Diagnosis: ______

If patient is a minor:

FATHER'S Name ______ SSN ______

Address ______

Cell # ______ Evening # ______

Employer ______ Work # ______

MOTHER'S Name ______ SSN ______

Address ______

Cell # ______ Evening # ______

Employer ______ Work # ______

In case of EMERGENCY, notify: ______

Relationship to patient ______ Phone # ______

PERSON(S) RESPONSIBLE FOR BILL: ______ ______

Primary Insurance Co: ______ Name of Insured: ______ DOB ______

Group No: ______ ID Number: ______

Insurance mailing address: ______

Phone Number: ______

I authorize the release of any information pertinent to my case to any insurance company, adjuster, attorney, or agency involved in this case. I understand that I am financially responsible for all charges incurred at Neuro*Therapy* Specialists, Inc.

Signature: ______ Date: ______

<u>WELCOME TO OUR OFFICE</u>

The professionals at NeuroTherapy Specialists, Inc. are committed to providing you and your family members with the finest physical, occupational, and/or speech therapy available. Our staff makes special efforts to consider all the needs of our patients by offering attention to every detail involved in your treatment from the moment you are greeted until your discharge.

Because we want you to be aware from the beginning of our service provisions, the following guidelines are provided to you regarding your financial arrangements:

<u>Payment</u> is due at the time services are rendered, unless our staff has approved payment arrangements in advance. We accept cash, checks, MasterCard, Visa, Discover, and American Express. We will be happy to help in processing your insurance claim for your reimbursement. In special instances, we may accept assignment of insurance benefits and allow you to make monthly estimated payments of your balance.

Returned checks are subject to an additional charge of **<u>$25.00</u>**. Appointment times are reserved especially for you and, if cancelled without 24-hour notice, will be subject to a cancellation fee of **<u>$45.00</u>**.

<u>Your insurance</u> is a contract between you, your employer, and your insurance carrier. As a **courtesy** to you, our Accounts Manager extends assistance to you to maximize your benefits; however you must realize

- Pre-certification does not guarantee benefits or verify eligibility.
- **All charges are your responsibility, regardless of the percent of insurance reimbursement.**
- Most insurance companies generally consider our fees as customary and within a reasonable range. Some companies arbitrarily define a fixed schedule, which bears no relationship to cost in this area.

We realize from time to time temporary financial problems may affect timely payment. If this should occur, we encourage you to promptly contact us for assistance in management of a comfortable payment arrangement.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I will notify you of any changes in my health insurance status.

I have read all of the information on this sheet and agree to the above guidelines.

_______________________________ _______________________

Signature (Parent/Guardian if patient is a minor) Date

11140 N. Harrell's Ferry Road Baton Rouge, Louisiana 70816 (225) 272-0150 FAX (225) 275-0930

<u>CLIENT GUIDELINES</u>

1. All patients are required to inform the front desk upon arrival. The receptionist will then alert your therapist of your arrival.

2. Your specific appointment time is set aside just for you. Please make every effort to be timely so that you can receive your full treatment. If you must cancel your appointment, a 24-hour notice is required (except if case of fever, infectious or contagious disease) to avoid the cancellation fee of **<u>$45.00</u>**.

3. Patients are charged either by the amount of time scheduled or by the service delivered, an evaluation, or special modalities such as moist heat, electrical stimulation, etc. Please speak to your therapist prior to treatment if you have any questions about your charges.

4. A conference fee or staffing fee of **$85.00** per therapist per 45 minutes will be charged to you at the time of the staffing. This service is not reimbursed by insurance.

5. A convenience fee of **$50.00** will be billed to you per semester, per therapist when your child is seen at a school or daycare. This will help defray the increasing costs of travel and personnel requirements for schools and daycares.

6. Parents and caretakers are encouraged to observe and/or attend any therapy session. Once your child is under the supervision of the therapist, you may leave; however, you must leave a telephone number where you can be reached in case of an emergency. Because your child's safety is our major concern, NeuroTherapy Specialists, Inc. asks that no patient be left unattended prior to their treatment session. It is mandatory that you be present to pick up your child at the end of the scheduled session time. NeuroTherapy Specialists, Inc. is not responsible for babysitting taking before or after treatment sessions.

7. NeuroTherapy Specialists, Inc. is not responsible for personal items brought with you on the premises and is released from all liability as a result of loss or damage thereto.

I have read the above statement and I understand and accept these guidelines of NeuroTherapy Specialists, Inc., and agree to be bound by the above.

____ ___________________________

Signature (Parent/Guardian if patient is a minor) Date

11140 N. Harrells Ferry Road Baton Rouge, Louisiana 70816 (225) 272.0150 FAX (225) 275-0930

CONSENT FOR TREATMENT

Patient Name: ____

NeuroTherapy Specialists, Inc. has informed me that I have freedom of choice in all aspects of mine or my child's treatment. I am free at any time to choose other facilities or clinics to provide services for my child or myself.

I also realize that grievances and/or complaints can be aired to the Administrator or Clinical Director at any time by personal interview or in written form at the family's discretion.

I agree to the following evaluation(s):

Physical Therapy _______

Occupational Therapy _______

Speech Therapy _______

HIPAA PATIENT CONFIDENTIALITY AND PRIVACY ACT

I have been given an opportunity to review the information pertaining to the HIPAA patient confidentiality and privacy act as regards all services provided by NeuroTherapy Specialists, Inc.

I give permission to share information about my therapy plan with the following persons:

____

Name Relationship

____

Name Relationship

Upon further review, I do **NOT** want any information disclosed at all to the following. I understand if this changes, it must be done in writing.

____

____

______________________________________ ________________________

Signature (Parent/Guardian if patient is a minor) Date

Name:____Date:____________________________

What are your goals for your child's program? Please be as specific as possible.

1.

2.

3.

4.

5.

Thank you for your input.