Consent for Secure/Release of Information

Patient Name: _____Date of Birth: _____
Address:_____

I/We hereby authorize and request DeLoach Therapy Services to secure and/or release medical, social, educational, and other clinical information regarding the patient named above. I/ We understand that this authorization may be revoked in writing at any time. Otherwise, this consent automatically expires two years from the date of the signature**.**

This authorization applies only to the following individuals/institutions: If not completed, no information will be released from the office.

Primary Care Physician:_____

Address:_____

Name: _____

Address:_____

Name:_____

Address: _____

I/We give permission for DeLoach Therapy Services to communicate via email, information, i.e., evaluations, therapy updates, and/or other clinical information regarding the patient listed above. Information will not be disclosed to anyone not specifically listed below.

Email Address:_____

Email Address:_____

I hereby further direct that a copy of this authorization shall be deemed to be as valid as the original for all purposes authorized herein.

Parent/Guardian Signature: _____ Date: _____

phone 337- 534-8978 **email:** deloachtherapyservices@lusfiber.net **Fax** 337-284-3040

Billing & Cancellation Policy

DeLoach Therapy Services is committed to providing you with the best therapy available. My ability to continue to provide treatment to your child is dependent on timely payment for services rendered. This Billing Policy explains your responsibilities regarding payment for your child's treatment and insurance reimbursements.

- A current prescription from your child's physician is required.
- All patients are required to fill out the credit card auto-draft form.
- In-Network Patients: All deductibles, co-payments/co-insurance, and/or other payments are due at the time of service. Pre-certification does not guarantee benefits or eligibility. As clinical providers being contracted with your insurance company, we have taken the responsibility of filing your charges directly to your insurance company. Some services may be denied by your insurance company secondary to plan, medical necessity, or other policy limitations. We will attempt to re-file a denied claim on your behalf one time. **If your claim is denied a second time, you are responsible for payment in full of all services denied or not covered by your insurance.**
- Out-of-Network Patients: All deductibles, co-payments/co-insurance, and/or other payments are due at the time of service. As a courtesy, DeLoach Therapy Services will file claims directly to your insurance company. If your insurance company does not pay the provider within 30 days, you may be asked to make payment in full for all services not paid within 30 days by your insurance. If payment is received from your insurance after 30 days, the payment will be applied as a credit to your account. The patient is responsible for all charges not covered by insurance. Keep in mind that all insurance companies issue a disclaimer stating that the information that they give you is NOT A GUARANTEE of benefits. Therefore, DeLoach Therapy Services cannot guarantee that your insurance carrier will reimburse services. **You are responsible for payment in full of all services denied or not covered by your insurance**.
- Self-Payment Patients: Payment is due in full at the time of service. • You may pay your fees by cash, check or credit card. • For your convenience, we will keep a credit card on file to cover any charges you are responsible for.
- NSF checks are charged a $25.00 service fee.
- **Charges Owed**: Payment is due at the time of service. Monthly payments are expected. Outstanding accounts without recent monthly payments are subjected to a pause in services. Accounts over $500 are subjected to a pause in services. Accounts delinquent for 90 days or more are sent to collections.
- **There is a "No-Show" fee of $50.00 for each appointment that your child misses unless you contact the therapist at least 24 hours before the scheduled appointment.** I understand that illness may arise less than 24 hours. In that case, the therapist will use her discretion as to if the patient should be charged for the missed visit. There may be additional fees or refuse to continue seeing a patient as a result of repeated "No-Shows". After four consecutive "No-Shows," you will forfeit a guaranteed time slot on the schedule.
- **There is a $15.00 late fee charged for every 15 minutes that the patient is late, or late to pick up.** • Consistent attendance is important to maximize the outcomes of your child's therapy. If sessions are cancelled consecutively, you will forfeit a guaranteed time slot on the schedule. By signing this agreement, I understand and agree that I am responsible for the balance on my account for any professional services rendered. I have read and understood the information presented and I agree to the above policy and procedures. Therapy will be initiated when the responsible parties have signed this agreement.

Child's Name:_____ Date of Birth:_____
Parent Signature:_____ Date:_____

Phone 337- 534-8978 **Fax** 337-284-3040

Email: deloachtherapyservices@lusfiber.net 132 Demanade Blvd. Lafayette, LA 70503

CREDIT CARD AUTO-DRAFT FORM

This form secures a method of payments. You may indicate your preferred charging frequency. **We cannot begin services until we have a card on file.** This form is required even if you have insurance coverage. You will be informed if you ever have a balance on your account.

Patient's name: _____

Card holder's name: _____

Card # _____ CVV # _____

Expiration date: _____ Zip code: _____

Frequency:

- ☐ WEEKLY
- ☐ MONTHLY
- ☐ EACH _____ OF THE MONTH
- ☐ AS TOLD

Phone # for billing concerns:

_____

Email address for billing/receipts:

_____

By signing this form, I agree to allow DeLoach Therapy Services to charge the above credit card for services rendered at their facility**. I understand if my account remains delinquent for 90 days or more, my card will be charged for outstanding charges despite frequency indicated on this form**. I agree to notify the office to update any credit card changes or expired cards.

Print name: _____

Signature: _____

Date: _____ Child's name: _____

DATE: _____

CHILD'S FULL NAME:_____DATE OF BIRTH:_____
MALE_____ FEMALE_____ HOME PHONE: _____
HOME ADDRESS:_____

BILLING ADDRESS: _____
PARENT 1 CELL: _____ **PARENT 2 CELL:** _____
EMAIL ADDRESS: _____
PARENT 1'S NAME: _____ OCCUPATION: _____
WORK #: _____ **EMPLOYER:** _____
PARENT 2'S NAME: _____ OCCUPATION: _____
WORK #:_____ **EMPLOYER:** _____
CHILD RESIDES WITH: ____BOTH PARENTS ___ PARENT 1 ____ PARENT 2 ____ Other

Primary Insurance Provider_____
Policy Number: _____ Policy Holder: _____
SSN of Policy Holder: _____
Date of Birth of Policy Holder: _____

Secondary Insurance Provider_____
Policy Number: _____ Policy Holder: _____
SSN of Policy Holder: _____
Date of Birth of Policy Holder: _____

EMERGENCY CONTACT NAME: _____
RELATIONSHIP: _____ PHONE NUMBER(S): _____
SCHOOL: _____GRADE:_____
TEACHER'S NAME: _____TYPE OF CLASSROOM: _____
REFERRED BY: _____REASON FOR REFERRAL: _____

NAME OF PROFESSIONALS YOUR CHILD HAS SEEN AND HOSPITAL/OFFICE AFFILIATED WITH:

Pediatrician:_____
Neurologist:_____
ENT: _____
Gastroenterologiist:_____
Ophthalmologist: _____
Psychiatrist/Psychologist: _____
Occupational Therapist: _____
Physical Therapist: _____
Speech Therapist: _____
Genetist:_____
Orthopedist_____
Other: _____

Describe how your child interacts with siblings or other children:

_____
_____

Describe the play activities in which your child engages:

_____
_____

Does your child play interactively well with peers?

_____
_____

Does your child play independently?

_____
_____

What are your primary concerns/what are you hoping for the physical therapist to address? (e.g., coordination, clumsiness, toe walking, physical difficulties with activities/play)

_____
_____

What are your goals for physical therapy?

_____
_____

Please list any medical precautions/allergies:

_____
_____

Is your child receiving any other services? (i.e. speech, occupational therapy, special education, early intervention)

_____

What (if any) special equipment does your child use?

Wheelchair_____ Eyeglasses _____ Hearing Aids _____ Braces/Orthotic _____

Walker _____ Communication Device _____ Crutches _____ Other _____

Medications:

List any medications that your child is currently taking and their purpose:

Medication: _____Purpose: _____

Medication: _____Purpose: _____

Developmental Milestones: Fill in the blanks to describe your child to the best of your ability:

Rolled over at ___ months/yrs
Sat at ___months/yrs
Talked at ___ months/yrs
Walked at ___months/yrs
Toilet trained at _months/yrs
Stood at ___months/yrs
Dressed at ___months/yr
Fed self at ___ months/yrs
Crawled at ___months/yrs

If there was anything unusual you noticed in any if the above developmental milestones, please explain:_____
_____
_____
_____

Activities of Daily Living (Routine Activities):

Check the type of assistance that your child requires during the following tasks:

	Independent	Verbal Assistance	Physical Assistance (minimal-maximal)
Going up stairs			
Going down stairs			
Walking on smooth surfaces			
Walking on uneven surfaces (like grass)			
Running			
Jumping			

Comments:
_____
_____
_____

Hearing/Vision:

Has your child ever had a vision test? _____ Date of last vision test: _____

Results: _____

Has your child ever had a hearing test? _____ Date of last hearing test: _____

Results: _____

PREGNANCY AND BIRTH HISTORY PRENATAL HISTORY:

1.Did the child's mother have any infections/illnesses during pregnancy? _____ Yes _____ No
Please describe: _____
2. Did the child's mother have any unusual stresses or shocks during pregnancy? _____ Yes _____ No
Please describe: _____
3. Did the child's mother receive any medication during pregnancy? _____ Yes _____ No
Please describe: _____
4. Did the child's mother have any complications during delivery/labor? ____Yes_____No
Please describe_____
5. Was the child born _____ full term or _____ premature?
6. Number of weeks: _____ Weight at birth: _____
7. Was labor induced? _____ Yes _____ No
If yes, reason for induction_____
8. What type of delivery (please circle)? Vaginal Cesarean Section (elective or emergency)
Presentation: Head Face Breech Transverse
Assistance: Forceps Suction other
9. Did the child have any birth injuries? _____ Yes _____ No
Describe: _____
10. What was the baby's APGAR scores? (IF KNOWN) 1 minute_____ 5 minutes____
11. Did the child require intensive care hospitalization? _____ Yes _____ No How long? _____
12. Was the child jaundiced? _____ Yes _____ No Length of treatment _____
13. Did your child pass the newborn hearing test? _____ Yes ____No

MEDICAL HISTORY OF CHILD

Has the child ever been hospitalized or had any surgeries? _____ Yes _____ No
If yes, when, where, & why: _____
Please note any medications and/or vitamin supplements your child is currently taking, the dosage, and intended purpose: _____
Has the child received previous evaluation and/or treatment by an occupational, speech-language, and/or physical therapist(s)? ____ Yes ____ No
If yes, where and dates of treatment: _____
Does the child have a medical diagnosis? _____ Yes _____ No
If yes, describe: _____
Has the child had a vision test? _____ Yes _____ No
If yes, when and describe results: _____
Has the child had a hearing test? _____ Yes _____ No
If yes, when and describe results: _____
Are there any medical precautions your therapist should be aware of when working with your child?
_____
Does your child have any allergies? If so, please list.
_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU AND/OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, therapist, and other health care personnel that are involved in your care and treatment for the purpose of providing health care services to you, to support the operations of the practice, and any other use required by law. **Treatment:** Your protected health information will be used and disclosed to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Healthcare Operations: Your protected health information will be used or disclosed, as needed, in order to support the business activities of the practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. Your health information may be reviewed during the routine processes of certification, licensing, or credentialing activities. **Patient Reminders:** Because consistent care is very important in your therapy, you will be reminded of scheduled appointments. They may include telephone reminders or electronic reminders such as email (unless you inform the office that you do not want to receive these reminders).

Abuse or Neglect: Government authorities will be notified if it is believed that a patient is the victim of abuse, neglect, or domestic violence. This disclosure will be made only when I am compelled by ethical judgment, when I believe I am specifically required or authorized by law, or with the patient's agreement.

Public Health and National Security: It may be required to disclose to Federal officials or military authorities' health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment, or medical device.

Law Enforcement: As permitted or required by State or Federal law, your health information may be disclosed to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are the victim of a crime or in order to report a crime.

Family, friends, and caregivers: With your permission, your health information may be shared with those you tell us will be helping with your therapy program or payment. I will be sure to ask your permission first. In the case of an emergency, where you are unable to communicate what you want, best judgment will be used when sharing your health information only when it will be important to those participating in providing your care.

Date and Sign _____

Assignment of Benefits and Consent for Treatment Acknowledgement of Policies and Procedures

I authorize the release of all medical and/or further information necessary to process all claims pertinent to my medical care for services rendered by DeLoach Therapy Services.

I authorize treatment and procedures to be performed by DeLoach Therapy Services.

Insurance coverage does not guarantee payment of services, my signature below acknowledges that I understand that I am financially responsible and accept liability for all charges incurred at DeLoach Therapy Services.

By signing this form, I acknowledge that I have received a copy and am in agreement with DeLoach Therapy Services Notice of Privacy Practices, Billing Policy, and Consent for Release of Information.

Patient Name: _____ Date of Birth: _____
Parent/Guardian Signature: _____ Date: _____

Consent to Videotape & Photograph Therapy Sessions

Name of Patient (print) _____

I, _____, give *Beth DeLoach/DeLoach Therapy Services* permission for my child, _____, to be photographed and/or videotaped by *Beth DeLoach/DeLoach Therapy Services*. **I understand these photos and/or videos are taken of children participating in therapy to illustrate therapy. I understand neither the name of my child nor any diagnosis will be identified.** Photographs and videos of my child may be shared in the following manner (check those that apply):

_____ Post pictures/videos to DeLoach Therapy Facebook page
_____ Post pictures/videos to DeLoach Therapy website
_____Other staff and specialists working with my child (ex. teachers, therapists, doctors) per written authorization
_____ Work projects given to parents
_____ *Send/Receive parent pictures/videos via text message: provide phone #_____ _____
_____ *Send/Receive parent email pictures/videos via email: provide email address _____

**If you choose to communicate protected healthcare information (e.g., video/pictures) by email or text messaging, please be aware you are consenting to potential email/text risks. Please note not all email/texts are secure and therefore Beth DeLoach/DeLoach Therapy Services cannot guarantee that information transmitted will remain confidential.*

Permission is voluntary and, as such, I/We relieve and hereby agree to hold *Beth DeLoach/DeLoach Therapy Services*, its representatives free and harmless from all liability arising out of such photographs/videos. I have authorization to make the above decisions and represent any family members/guardians involved. Any requested restrictions are described below. I understand that I may revoke this authorization at any time by notifying *Beth DeLoach/DeLoach Therapy Services* in writing. The revocation will not affect any actions taken before the receipt of this written notification. Images will be kept as long as they are relevant and after that time destroyed.

_____ _____
Signature of Parent/Legal Guardian Date

____ I do not want my child photographed or recorded for any purpose

____ I place the following restrictions on any photographs or video recording of my child:

_____

_____

Consent for Student to Observe OT Session

At DeLoach Therapy, we have several students from different Universities who would like to pursue a career in occupational therapy. There are many students who would like to come observe as our therapist treat your child. This is a great opportunity for students to increase their knowledge and gain a greater understanding of what occupational therapy truly entails. With that being said, please indicate below whether or not you will agree to allow a student, or students, to observe our occupational therapist during your child's treatment. The students are aware of privacy rules in this field and have signed a form stating so. Also, please be aware that students will not interfere in any way during your child's session. They are only there to observe.

I, _____, **WILL ALLOW** students to observe sessions with my child, _____, at DeLoach Therapy.

I, _____, **WILL NOT ALLOW** students to observe sessions with my child, _____, at DeLoach Therapy.

Date: _____