



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.
- **There is a \$15.00 late fee charged for every 15 minutes that the patient is late, or late to pickup.**
- Consistent attendance is important to maximize the outcomes of your child's therapy. If sessions are cancelled frequently, 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. Forms indicating to charge "as told" or "never" will not be charged unless accounts are 90 days overdue. We will attempt to reach you once by phone and once by email before charging an "as told" or "never" credit card.

Patient's name: _____

Card holder's name: _____

Card # _____ CVV # _____

Expiration date: _____ Zip code: _____

- Frequency:
- WEEKLY
 - MONTHLY
 - EACH _____ OF THE MONTH
 - AS TOLD
 - NEVER (WILL USE CASH/CHECK)

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: _____

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

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: _____

Gastroenterologist: _____

Ophthalmologist: _____

Psychiatrist/Psychologist: _____

Occupational Therapist: _____

Physical Therapist: _____

Speech Therapist: _____

Genetist: _____

Orthopedist: _____

Other: _____

PART 2: 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

PART 3: 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.

PART 4: DEVELOPMENTAL HISTORY

Please list the age that your child met the following milestones:

Rolled over independently _____	Sat up Alone _____	Said first Word _____
Crawled (hands&knees) _____	Walked Alone _____	Potty Trained _____
Ate solid foods _____	Drank from open cup _____	

Do you feel your child was "faster" or "slower" than his/her peers in any other way? Please explain _____

Does your child have or had any problems with any of the following?:

YES	NO	Description	Explanation
		Feeding Problems	
		Bed Wetting	
		Potty Training	
		Drooling	
		Thumb sucking	
		Temper tantrums	
		Head banging/aggression /destructiveness	
		Major mood swings	
		Under/Over reactive to sound	
		Under/Over reactive to touch	
		Under/Over reactive to taste/smell	
		Any unusual fears?	

What does your child drink from? Please check all that apply:

Bottle Sippy Cup Straw Cup Open Cup Other

How does your child play with other children?

What is your child interested in? (Movies, toys, activities, etc.) _____

Explain in detail your child's current diet.

Describe your child's sleep patterns?

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: _____