**PATIENT INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M F Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: FL Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell/Alternate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_\_ Age: \_\_\_\_\_\_\_\_ Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Onset: \_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_

**I certify the above information is correct. I authorize the treatment for Early Intervention, Physical, Speech and/or Occupational Therapy Services, and the release of information for claim purposes. I understand the payment for these services will be directed to Suncoast Therapy.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pt./Legal Guardian Signature Date

**INFORMATION RELEASE AND FEE SCHEDULE**

**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_ I. **AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize Suncoast Therapy to release and receive medical records information to/from:

\_\_\_\_\_\_\_\_ Insurance Companies/Physician

\_\_\_\_\_\_\_\_ School Board County of \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_ Early Steps Program

\_\_\_\_\_\_\_\_ Other

\_\_\_\_ II. **FEE SCHEDULE**

$27.50 per unit (1-15 min.) individual

You will be billed monthly for therapy charges. The billed amount is **due upon receipt**.

All families eligible for the Early Steps program, as indicated by an ACTIVE IFSP, will not be responsible for payment. By signing below you understand that your insurance company will be *billed first*, for services provided and if they do not pay for services, regardless of the reason, Early Steps will be billed as the payer of last resort.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

**HIPPA Compliance Notification for Our Patients**

To Our Families,

The misuse of protected health information has been identified as a national problem causing some patients inconvenience, aggravation, and costing them money. We want you to know that all of our employees, managers and therapists periodically receive training to assist them in understanding and complying with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with a particular emphasis on the “Privacy Rule.” We strive to achieve the highest standards of ethics and integrity in performing services for our patients.

When it is appropriate and necessary, we provide the minimum necessary information. Other entities may have indirect treatment relationships with you (such as the physician reading your reports) and we may need to disclose personal health information for the purpose of treatment or payment. These entities are most often not required to have patient consent.

You may refuse, in writing, the consent to disclose your personal health information. Under the law, we then have the right to refuse to treat you, should you refuse to disclose your personal health information. At any time in the future, you may request to refuse all or part of disclosure to your personal health information. However, you cannot revoke actions that have already been taken which relied on this or a previously signed consent.

It is our policy to determine appropriate uses of personal health information in accordance with the government rules, laws, and regulations. We want to make sure that our office never contributes to the growing problem of improper disclosure of personal health information. We have implemented a program we believe will help us prevent an inappropriate use of personal health information.

We also know that we are not perfect! Because of this fact, our policy is to listen to our patients and employees without any thought of penalty if they feel that an event in any way compromises our policy or integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. If you have any questions please ask to speak with any one of our staff concerning the problem.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Print Patient Name Signature of Patient/Guardian Date

**Confidentiality Statement**

In accordance with Health Insurance Portability & Accountability

Act of 1996 (a Federal Law)

It is the office policy of Suncoast Therapy to not release confidential and/or unauthorized information. When returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. If you require healthcare information to be released to someone other than yourself, please complete the following:

I authorize Suncoast Therapy to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

May we reach you at home? Yes No

May we confirm your appointments by answering machine or text? Yes No

If you are employed, may we contact you at work? Yes No

May we leave a message for you at work? Yes No

It is important to keep you other physicians informed about your care.

If needed, may Suncoast Therapy release medical records to Yes No  
your other physicians?

Please list names of authorized people:

Parent(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Or other person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Rights and Complaint Process**

I understand that I have a right to refuse treatment at any time. I have a right to review my records, diagnosis, and treatment plan. I understand that if I feel that my rights have been violated, it is my right to file a complaint with the State of Florida.

I certify that I have read and understand the above and I accept all specified terms and fees therein, and have received information on patient rights including the process for initiation, review, and resolution of complaints.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Print Patient Name Signature of Patient/Guardian Date

**Patient/Family Financial Responsibilities**

Thank you for choosing Suncoast Therapy to provide therapy services to your child. We are committed to providing your child with the highest quality services. Please review our financial policies outlined below and ask if you have any questions.

Please initial each statement to acknowledge your understanding and acceptance.

|  |  |
| --- | --- |
|  | **If You HAVE Insurance:** |
|  | Our ability to collect payment from your insurance carrier depends on the accuracy of the information you provide to us. Please let us know immediately when there are changes to your insurance coverage or contact information.  While filing insurance claims is a courtesy we offer our patients, all charges are your responsibility from the date services are rendered. Your insurance is a contract between you and your medical insurance provider and we are not a party to that contract. Although we may estimate what your insurance might cover and pay, it is the insurance company that makes the final determination of your eligibility and benefits.  Not all services are a covered benefit in all policies. **As guarantor, it is your responsibility to know your insurance policy, and be familiar with its coverage and payment rules**. **You will be responsible for all charges not covered by your plan, including those charges in excess of the maximum allowed visits granted on the insurance authorization.**  Following your appointment, we will file a claim with your insurance company. After receiving an Explanation of Benefits (EOB) from your provider, we will bill you for any charges not covered by insurance as well as for any balance your insurance company deems your responsibility (co-insurance, unmet deductible). For clinic appointments, applicable co-pays may be collected at time of appointment.  Please be aware that some private insurance companies can take four to six weeks or longer to turn around an Explanation of Benefits (EOB) statement. Please plan ahead since you may accumulate charges for multiple visits during this time, and you will be responsible for all charges not covered by insurance. |
|  |  |
|  | **If You Do NOT Have Insurance:** |
|  | All charges are your responsibility from the date services are rendered. You will be billed on a monthly basis. |
|  |  |
|  | **If You Have an Individualized Family Service Plan (IFSP):** |
|  | All families eligible for the Early Steps program (as indicated by an ACTIVE IFSP) are not responsible for payment. Your insurance company will be *billed first* for services provided, and if they do not pay for services, regardless of the reason, Early Steps will be billed as the payer of last resort. |
|  |  |
|  | **Cancellation Fee:** |
|  | Consistency in services is important for successful progress. Please contact us 24 hours in advance if you need to cancel or reschedule your appointment. Appointments missed and not previously cancelled may be charged a fee of $40.00. |
|  |  |
|  | **Returned Checks:** |
|  | There is a fee of $20.00 on all returned checks not honored by the bank. |
|  |  |
|  | **Billing Questions:** |
|  | Our parent company, Progressus Therapy, handles our billing. If you have questions about your bill, please contact Progressus Therapy at (800) 892-0640. |
|  |  |
|  | **Past Due Accounts:** |
|  | If your account becomes past due, Suncoast Therapy reserves the rights to:   * Report non-payment of co-pays, co-insurance and deductibles to your insurance carrier. * Report past-due balances to an outside collection agency, at which time you will be responsible for the outstanding charges, and any applicable collection agency and attorney fees. * Discontinue services due to non-payment. |
|  |  |

***By signing below, I acknowledge that I have read and understand the financial policies described above, and have had the opportunity to ask questions.***

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| --- | --- |
| **Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |
|  |  |
| **Responsible Party:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |
|  |  |
| **Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |