1229 Toteros Drive
Waxhaw, NC
28173
P) 704-649-4509
F) 704-843-9045

PATIENT INFORMATION:

Name: _____

DOB: _____ Sex: ❑ Male ❑ Female

HOW DID YOU HEAR ABOUT US?

_____

PARENT/GUARDIAN INFORMATION:

Name: _____ ❑ Parent ❑ Legal Guardian ❑ Other: _____

Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

INSURANCE INFORMATION:

Insurance Carrier: _____ Phone Number: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Policy Holder DOB: _____

Effective Date: _____

Secondary Insurance: _____ Phone Number: _____

Policy Number: _____ Effective Date: _____

PHYSICIAN INFORMATION:

Practice: _____ Physician Name: _____

Phone Number: _____ Fax Number: _____

Address: _____ City: _____ State: _____ Zip: _____

REQUESTED THERAPY (Please check all that apply): ❑ Occupational ❑ Physical ❑ Speech

Where would you like therapy to take place?

❑ Home ❑ Office ❑ Daycare/Preschool (Facility Name) _____ ❑ Other: _____

AREAS OF CONCERN: ❑ Behavior ❑ Fine Motor Skills ❑ Gross Motor Skills ❑ Sensory ❑ Self-care ❑ Speech ❑ Feeding/Swallowing

Please describe any relevant medical history, diagnosis or concerns: _____

_____

_____

_____

PRIVACY NOTICE ACKNOWLEDGMENT

I certify that I received a copy of Milestone Therapy's Privacy Practices (included in this packet) and that I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanation provided to me and I am confident that the facility is committed to protecting my health information. This acknowledgement will remain in effect indefinitely, unless otherwise revoked by a written, dated request.

Signature: _____ Date: _____

MILESTONE THERAPY, INC.

OFFICE POLICIES

CONSENT FOR TREATMENT OF A MINOR: As a parent and/or legal guardian, I authorize Milestone Therapy, Inc. to evaluate and/or treat_____(minor's name).

CONSENT FOR CARE &TREATMENT: A licensed Therapist will complete an evaluation by examination of your child and parent interview. Your child's treatment program will then be designed. A variety of treatment techniques may be used. Your signature below is an indication of your consent for Milestone Therapy Inc. to furnish therapeutic services and treatment considered necessary and proper in evaluating or treating your child's condition.

ASSIGNMENT & RELEASE OF BENEFITS: Your signature below authorizes the release of any medical and/or other information necessary to process your insurance claim. I hereby assign my insurance benefits to be paid directly to Milestone Therapy Inc..

FINANCIAL POLICY: We will bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. If you change insurance coverage while undergoing treatment, it is your responsibility to notify the office of this change. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. **Your insurance benefits as quoted to us by your insurance carrier will be reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation**. You are encouraged to communicate directly with your insurance carrier for confirmation of benefits quoted to us. We have reviewed these benefits with you and you agree to pay your portion of this bill. Should your claim be denied by your insurance carrier, you will be responsible for paying for the services rendered.

Accounts 90 days past due will be sent to collections. If formal collection procedures become necessary you will be responsible for additional costs incurred. Checks returned for non-sufficient funds may be subject to a $25 processing fee.

- ❑ Please bill my insurance carrier on my behalf. I have been informed of my benefits as quoted by my insurance carrier to Milestone Therapy Inc.. I understand that ultimately it is my responsibility to know the extent of benefits. _____ **(please initial)**

- ❑ I choose to self-pay for services rendered. I further understand that no insurance company will be billed by Milestone Therapy Inc.. _____ **(please initial)**

RELEASE OF INFORMATION:

___**I DO** ___ **I DO NOT** Give permission to Milestone Therapy Inc. to release or obtain information in my child's records to or from Pediatricians, Schools and any other interested parties requested. This information may include: IEP, Screening Reports, Evaluation Reports, Visit Notes, Treatment Plans and Discharge Summaries. This authorization is valid until Milestone Therapy receives a termination request in writing.

___**I DO** ___ **I DO NOT** Give permission to Milestone Therapy Inc. to communicate with me regarding my child's personal health information via the email address provided. I understand that this information is not encrypted and transmitted over the Internet therefore leaving the possibility of a third party accessing it.

CANCELATION & NO-SHOW POLICY:

A scheduled appointment must be cancelled at least 24 hours in advance. We ask that you notify your therapist 2 weeks in advance of any upcoming planned vacations or extended leave of absence. Failure to show up for an appointment ("NO SHOW") without notifying your therapist will be documented. Consecutive no-shows will result in the cancellation of all remaining scheduled appointments. Consecutive cancellations will also result in a termination of services. In signing this document you are indicating that you understand this policy and the consequences of not keeping your appointments. Thank you for your cooperation.

I have reviewed the above information and have asked for clarification of any items not fully understood. I UNDERSTAND THAT IT IS MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____
Print Full Name

_____ _____
Guardian/Responsible Party Signature Date

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Does your child have an IEP? ❑ Yes ❑ No

If YES, please complete the remaining page.

Child's Name: _____ Date of Birth: _____

School's Name _____ Phone Number: _____

Grade Level_____ Teacher's Name _____

So that Milestone Therapy can obtain a copy of your child's IEP for our records, please complete and sign below. Thank you!

AUTHORIZATION TO OBTAIN IEP RECORDS

I give Milestone Therapy permission to request a copy of my child's IEP from the school listed above for their records. I understand that I can revoke this authorization at any time in writing.

_____ _____
Signature Date

SPEECH THERAPY REFERRAL QUESTIONS

1) What language(s) does this child speak/understand? _____

2) What is this child's PRIMARY language? (language used/understood the MOST) _____

3) What language is spoken most in the home? _____

4) Does your child use an AAC device to communicate? ❑ Yes ❑ No

5) Primary concerns: SPEECH (sounds), LANGUAGE (understanding/making sentences), FEEDING, STUTTERING, or another concern?

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!!!PLEASE KEEP FOR YOUR RECORDS!!!

NOTICE OF PRIVACY PRACTICES

Milestone Therapy Inc. is required by law to protect the privacy of your personal health information, provide this notice about information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Milestone Therapy Inc. uses your personal health information primarily for treatment, obtaining payment for treatment, and evaluating the quality of care we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health benefits that could be of interest to you. We may also use or disclose your personal health information without prior authorization for public health and auditing purposes, research studies, or for emergencies. We also provide information required by law.

YOUR INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. We will consider all such requests on a case-by-case basis, but Milestone Therapy Inc. is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Milestone Therapy Inc. may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Rehabilitation Director at the address below. You may file a written complaint to the US Department of Health and Human Services. We will not retaliate against you for filing a complaint.

Milestone Therapy Inc.
Attn: Rehab Director
741 Kenilworth Avenue, Suite 100
Charlotte, NC 28204

DISCRIMINATION POLICY

Milestone Therapy Inc. is fully committed to policies of non-discrimination. It is the practice of the corporation to prevent any form of discrimination, harassment, or prejudicial treatment on the basis of race, color, religion, national origin, sex, age, sexual orientation, or status of disabled individual or disabled veteran.
*Borrowed from the Civil Rights Act of 1964 and the American with Disabilities Act

!!!PLEASE KEEP FOR YOUR RECORDS!!!