2300 Gallberry Lane
Waxhaw, NC 28173
P) 704-649-4509
F) 704-843-9045

PATIENT INFORMATION:

Name: _____

DOB: _____ Sex: ❑ Male ❑ Female

PARENT/GUARDIAN INFORMATION:

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

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

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

INSURANCE INFORMATION: ❑ Commercial insurance Plan (BCBS, Cigna, Aetna, etc.) ❑ Medicaid ❑ Both ❑ None

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: _____

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). 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.

Services listed on your child's IEP are the financial responsibility of the school. In an effort to help the school, Milestone Therapy will utilize any insurance policies and benefits available to your child. We will only bill your insurance with your written consent. Your consent may be withdrawn at any time. Anything not covered by your insurance will be billed to the school.

- ❑ I authorize Milestone Therapy to bill my insurance for services listed on my child's IEP. _____ **(please initial)**
- ❑ I DO NOT give Milestone Therapy consent to bill my insurance for services provided on my child's IEP._____ **(please initial)**

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..

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.

___**I DO** ___ **I DO NOT** Give Milestone Therapy permission to communicate with me via text message. These texts will not contain protected health information. Text messages might be used to confirm appointments, request missing information, communicate updates to our waitlist and more.

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: _____

Please sign and date below indicating that you have carefully read and understand our Office Policies and will abide by them.

_____
Print Full Name

_____ _____
Guardian/Responsible Party Signature Date

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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
2300 Gallberry Lane
Waxhaw, NC 28173

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!!!