1229 Toteros Drive
Waxhaw, NC 28173

P) 704-649-4509
F) 704-843-9045

PATIENT INFORMATION:

Name: ____ DOB: ______________

SSN: _________________________ Sex: ❑ Male ❑ Female

HOW DID YOU HEAR ABOUT US?

____

PARENT/GUARDIAN INFORMATION:

Name: ____ ❑ Parent ❑ Legal Guardian ❑ Other: ___________________________

Address: ____ City: ___________________ State: _______ Zip: ____________

Home Phone: ______________________________ Work Phone: ___________________________________

Cell Phone: ________________________________ Email Address: ____

Please indicate how you would like Milestone to bill for your therapy services:

- ❑ Send all claims through my insurance company. Any charges not covered by my insurance, bill to the school.
- ❑ Do NOT bill my insurance/Medicaid. The invoice will go straight to the school.

INSURANCE INFORMATION: (If you do not wish your insurance to be billed, you may skip this section)

Insurance Carrier: _____________________________ Policy Holder: _____________________________ Policy Holder DOB: ______________

Phone Number: _______________________________ Effective Date: ________________________

Policy Number: _______________________________ Group Number: ________________________

Secondary Insurance: _____________________________ Policy Number: _______________________ Phone # ________________________

PHYSICIAN INFORMATION:

Practice: ____ Physician Name: ____

Phone Number: _______________________________ Fax Number: _______________________________

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

Please describe all areas of concern:

____

____

____

CONSENT FOR TREATMENT

I give permission for my son/daughter (circle) ______________________ to receive an evaluation and treatment as needed to meet the individual needs of my child.

Signature: ____ Date: ________________________

RELEASE OF INFORMATION

❑I Do ❑I Do Not Give permission to Milestone Therapy to release information in my child's records **at my request** to Pediatricians, Schools and any other interested parties requested. This information may include: Screening Results, Evaluation Reports, Visit Notes, Treatment Plans and Discharge Summaries.

Signature: ____ Date: ________________________

FINANCIAL RESPONSIBILITY

I authorize the release of any medical or other information necessary to process any claims. I hereby assign my insurance benefits to be paid directly to Milestone Therapy.

Signature: ____ Date: ____________________

PRIVACY NOTICE ACKNOWLEDGMENT

I certify that I received a copy of Milestone Therapy's Privacy Practices (the second page of 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: _______________________

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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!!!