working wonders in children's lives

THERAPYWORKS
7608 E. 91st Street
Tulsa, OK 74133
ph 918.663.0606
fax 918.663.8754
www.therapyworkstulsa.com

PATIENT INFORMATION

DATE: _____

PATIENT: _____ **DOB:** _____

THERAPIES RECEIVING: **PT**_____ **OT**_____ **ST**_____ **FT**_____

RESPONSIBLE PARTY: _____ **HOME PHONE:** _____

MAILING ADDRESS: _____
City **State** **Zip**

☐ Mailing address and billing address are the same

BILLING ADDRESS: _____
City **State** **Zip**

PRIMARY CONTACT NUMBER: _____ **SECONDARY:** _____

MOTHER/GUARDIAN'S CELL PHONE: _____ **WORK PHONE:** _____

FATHER/GUARDIAN'S CELL PHONE: _____ **WORK PHONE:** _____

FAMILY E-MAIL ADDRESS: _____

☐ **Yes**, I would like to receive e-mail notices, including the TherapyWorks newsletter, upcoming patient reward programs, and special events. (TherapyWorks will keep all information confidential and the information will not be disclosed to any outside vendor.)

☐ **No**, I would not like to receive electronic communications from TherapyWorks.

PHYSICIAN: _____ **PHONE:** _____

MOTHER/GUARDIAN'S NAME: _____ **DOB:** _____

EMPLOYER: _____ **SSN:** _____

FATHER/GUARDIAN'S NAME: _____ **DOB:** _____

EMPLOYER: _____ **SSN:** _____

PRIMARY INSURANCE: _____ **POLICY HOLDER'S SSN:** _____

GROUP NUMBER: _____ **ID NUMBER:** _____

INSURED: _____ **RELATIONSHIP:** _____ **DOB:** _____

SECONDARY INSURANCE: _____ **POLICY HOLDER'S SSN:** _____

GROUP NUMBER: _____ **ID NUMBER:** _____

INSURED: _____ **RELATIONSHIP:** _____ **DOB:** _____

PLEASE LET US MAKE A COPY OF YOUR INSURANCE CARD(S) FOR OUR RECORDS

DATE VERIFIED: _____ INITIALS: _____

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PATIENT MEDICATION RECORD

Patient: _____ **DOB:** _____
(Please print full name)

Parent/Guardian: _____

CURRENT LIST OF ALL ALLERGIES

FOOD	MEDICATION

LATEX _____**Yes** _____**No**

CURRENT LIST OF ALL MEDICATIONS

DATE	MEDICATION	DOSAGE	SIGNATURE

_____ _____
Parent or Guardian Signature Date

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CONSENT TO TREAT

Patient: _____ **DOB:** _____
(Please print full name)

I hereby authorize TherapyWorks, Inc. to perform occupational, physical, speech and/or nutrition therapy evaluations, administer therapeutic treatment as recommended in the initial evaluation and provide clinical services as deemed necessary by TherapyWorks, Inc. I understand that I will receive an explanation in understandable terms of the therapy recommended for the above named person, including possible side effects associated with treatment.

RELEASE OF CONFIDENTIAL EVALUATION AND TREATMENT RECORDS TO AND FROM THERAPYWORKS

From TherapyWorks:

I hereby authorize TherapyWorks, Inc. to release photocopies of my medical records and/or health information to the following individual(s) or organization(s):

Physician	
Name: _____	Phone: _____
Address: _____	Fax: _____
Specialist	
Name: _____	Phone: _____
Address: _____	Fax: _____
School	
Name: _____	Phone: _____
Address: _____	Fax: _____
Family Member	
Name: _____	Phone: _____
Address: _____	Fax: _____

To TherapyWorks:

I, the undersigned, do hereby authorize the above sources to release educational, medical, surgical and/or psychological reports from the patient's records. This information is protected under the Heath Insurance Portability and Accountability Act (HIPAA) The information should be sent to:

TherapyWorks, Inc.
7608 East 91st Street ♦ Tulsa, OK 74133
Phone: (918) 663-0606 ♦ Fax: (918) 663-8754
E-mail: info@therapyworkstulsa.com
www.therapyworkstulsa.com

I understand that I may revoke this treatment consent or revise this release at any time by written request except to the extent that action has already been taken. I further release TherapyWorks, Inc. from the responsibility of any effect the release of my clinical medical records may have upon myself or others both now and in the future. I personally accept all responsibility for my own distribution and interpretation of medical information contained therein and hold TherapyWorks, Inc. blameless for conclusions or opinions drawn without professional knowledge, assistance or review.

_____ _____
Parent or Guardian Signature Date

_____ _____
Parent or Guardian (Print Name) Date

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Payment and Insurance Acceptance Policy

Patient: _____ **DOB:** _____
(Please print full name)

If you do not have insurance coverage, payment in full is expected when services are rendered. When you pay at the time of service, you will receive a 20% discount off total charges billed.

If you have insurance coverage, co-payments and/or co-insurance, including deductible amounts, are due when services are rendered. TherapyWorks makes every effort to verify your insurance benefits before your initial visit. **Your insurance company makes no guarantee of payment upon our call to verify your insurance benefits.** We will proceed to file all claims with your insurance company. If there are insurance issues, we will provide all requested documentation to your insurance company and re-file claims if necessary. If, for any reason, your insurance company denies payment, you will be responsible for payment of all outstanding services that have been rendered.

We require a 24-hour cancellation notice. Two (2) no-show appointments or four (4) of twelve (12) cancelled appointments will result in all future appointments being removed from the schedule. At that time, you will need to schedule your child's appointments on a week-to-week basis.

If you have any questions regarding this policy, please do not hesitate to ask.

Patient Financial Responsibility and Assignment of Benefits

I hereby authorize TherapyWorks, Inc. to furnish my insurance company(s) or to designated attorney, all information that said insurance company(s) or attorney may request. I hereby assign to TherapyWorks, Inc. all payments which I may receive from the insurance company for medical expenses relative to the service rendered, but not to exceed my indebtedness to said clinic. It is understood that payments received from the insurance company(s) over and above any charges incurred, will be applied to my account as a credit to use against future co-payments or visit charges.

I understand that I am fully responsible to TherapyWorks, Inc. for all charges not covered by the assignment of my insurance. Examples of non-covered items may include but are not limited to Medical Necessity, Developmental Delay, Ineligible for Coverage, or Non-Covered Benefit. The parent/guardian will be billed for any outstanding balances on their account after insurance has either rendered a payment and/or a final decision on the status of the open claim. Payment Plans are available through our billing department. In the event of non-payment, I further understand that my account will be turned over to a collection agency for processing, which will cause irreparable damage to my credit rating.

I have read the above and fully understand my responsibility for all treatment received.

_____ _____
Parent or Guardian Signature Date

_____ _____
Witness Date

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient: _____ **DOB:** _____
(Please print full name)

A complete description of how your protected health information will be used and disclosed by TherapyWorks, Inc. is in our Notice of Privacy Practices. This notice is posted on our website (www.therapyworkstulsa.com) and hard copies are available at the front desk if you would like a copy for your personal use.

I acknowledge that I have received information about the privacy practices of TherapyWorks.

_____ _____
Parent or Guardian Signature Date

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Release for Photography/Videotaping

Patient: _____ **DOB:** _____
(Please print full name)

In the course of treatment, therapists may take photographs or video recordings of patients for internal uses such as documenting progress or providing parent training and internal education, and/or for external uses such as research, advertising, or company literature. Please determine which, if any, of these uses are acceptable for you and your child.

☐ I do **not** authorize TherapyWorks, Inc. to make photographs, videotapes, movies, or video recordings of my child.

☐ I hereby authorize TherapyWorks, Inc. to make photographs, videotapes, movies or video recordings of my child. I further consent that such tapes, films, photographs or biographical information may be used by TherapyWorks, Inc. completely free of compensation.

This permission includes the following:

Internal use:
- Documentation of progress, parent training, internal education

External use:
- Research, education, publication, company literature, advertising, or website production
- Background scenes during taping or photography of other patients

_____ _____
Parent or Guardian Signature Date

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Reminder Call Form

Patient Name: _____

I would like to receive reminder messages via:

□ E-mail:_____

or

□ Text Message: (_____)_____-_____

Phone Carrier: T-Mobile AT&T Cricket Sprint US Cellular
Verizon Virgin Mobile Other: _____