3801 Schroer Road, Valdosta, GA 31605
Phone: 229-244-3552 Fax: 229-244-7030

Finding the Key to Communication…

PATIENT INFORMATION Today's Date:________________

Patient's last name______________________________First______________________Middle_______
(Former name)____________________Birth date _____________Age__________Sex M F
Address:____Social Security no.________________

Please check preferred contact number

☐Home phone_____________☐Cell phone______________________☐Other__________________
Occupation________________Employer_________________________Employer phone____________
Chose clinic because/referred to clinic by (Choose) *Family* *Close to home/work*
Friend *Other* *Doctor* *Insurance plan* *Agency*
Other family members seen here____

INSURANCE INFORMATION (Please give your insurance card to the receptionist.)

Person responsible for bill____Birth date___________
Address (if different)____Home phone_______________
Cell phone______________________________Email address______________________________
Occupation______________________Employer____
Employer address_______________________________Employer phone__________________________
Is this patient covered by insurance? Yes No
Please indicate primary insurance Tricare BCBS United Healthcare
Medicaid Other____
Subscriber's name________________________Social Security______________Birth date___________
Policy Number_________________________________Group_____________________Copay $______
Patient's relationship to subscriber *Self* *Spouse* *Child* *Other*
Name of secondary insurance (if applicable)_________________________Social Security______________
Birth date___________Policy Number___________________________Group________Copay $______
Patient's relationship to subscriber *Self* *Spouse* *Child* *Other*

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)____________________________________
Relationship to patient_____________Home phone_______________Work phone________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Speech Language pathologist. I understand that I am financially responsible for any balance. I also authorize Keystone Therapy Services or insurance company to release any information required to process my claims.

Patient/Guardian signature____Date_______________

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INFORMED CONSENT FOR SPEECH THERAPY

I, ______________________________the parent/legal guardian of _________________________, hereby request and consent to Keystone Therapy Services, LLC to perform treatment and care for my child as prescribed by a physician and/or recommended by a speech-language pathologist.

I understand and am informed that, as in the practice of medicine, speech language and feeding therapy may have some risks.

I understand that I have the right to ask about these risks and have any questions answered about my child's condition, prior to treatment.

I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss it with the treating therapist.

I consent and authorize Keystone Therapy Services, LLC to administer treatment under the direction and supervision of a certified speech-language pathologist.

____ ___________________

Signature of Parent/ Legal Guardian Date

HIPAA AND OUR CLIENTS

The HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule became law in 2001. This rule essentially controls the use and disclosure of what is known as Protect Health Information (PHI). The confidentiality and security of PHI will be maintained by this entity and will used only for the purpose of treatment, payment and healthcare operations (TPO).

As an observer, I acknowledge receipt of the HIPPA Notice of Privacy Practices, and I understand and accept my responsibility of compliance as outlined in the policy and procedure.

____ ___________________

Signature of Parent/ Legal Guardian Date

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NO SHOW/ CANCELLATION POLICY

Keystone Therapy Services is committed to helping you and/or your child with your Speech Therapy needs. When you schedule an appointment with one of our therapists that time is reserved exclusively for you. We do understand that on occasion unforeseen circumstances do arise and the need to cancel your scheduled appointment may be necessary. If you do know that you will be unable to keep your appointment, we ask you to show consideration by calling, texting, or emailing your therapist 24 hours in advance. Providing our office with adequate notice will allow us to offer that appointment time to another person.

Effective April 1, 2012 a $25 charge will be assessed for “no showing” or failing to give 24 hour notice of the need to cancel all appointments.

These charges are not billable to your insurance and will ultimately be the responsibility of the client. All no show charges will need to be paid before your next appointment with the therapist.

_______________________________________ ________________

Signature of Parent/ Legal Guardian Date

CONSENT FOR SNACKS

I GIVE/ DO NOT GIVE (circle one) my permission to Keystone Therapy Services to distribute food and/or beverages during therapy and/or diagnostic sessions to:

____

Client’s name

Exclusions: (please include any food allergies, etc)

____

____

____

____

____

Print full name of client or guardian for minor

_______________________________________ ________________

Signature of Parent/ Legal Guardian Date

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RE: Appointment Reminder Release

I, ____(Print),

(Parent/Guardian)

Hereby authorize/ do not authorize (Circle one) **Keystone Therapy Services** to send me appointment reminders via email and/or text messaging using the following information:

Email and text reminders may contain patient or clinic information such as, but not limited to, patient first name and clinic location.

Parent/Guardian Contact Information:

(*Please print clearly and legibly)*

Client Name:

____

Email:

____

Cell Phone:

____

Parent/Guardian:

____

Signature:

____

Date:

____

Preferred Method: *(Circle One)* **Email** **Text** **Both**

Note to Office Managers:

Confirm that the E-mail and Cell Phone provided above match the information in the patient information screen.

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Finding the Key to Communication

As of July 1, 2013

CLIENT FINANCIAL POLICY

Thank you for choosing Keystone Therapy Services as your child's speech and language therapy provider. We are committed to providing your family with qualified affordable therapy. As our practice grows, we find it necessary to update all of our clients of our current financial policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be placed in your file and provided to you upon request. Any changes to our financial policy will be communicated in a timely fashion.

1. Insurance: We are a participating provider for most major insurance plans. It's very important that you know and understand your insurance benefits. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect any amount your insurance deems necessary for you to pay could be considered fraud.

3. Non-covered services: Please be aware that some of or all of our services may be considered non-covered or not considered reasonable or necessary by your insurance. These services must be paid for in full at the time of visit.

4. Proof of Insurance: All clients must complete our new client information form before seeing the therapist. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for all of the charges incurred and be temporarily designated as a self-pay client until verification coverage is received.

5. Self-Pay: If you are not covered under an insurance plan, you will be considered self-pay and payment in full is required at the time of service.

6. Claims submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

7. Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim, the balance will be billed to you.

8. Nonpayment: We will supply you with a statement each month concerning any outstanding balances. It is your responsibility to pay any outstanding balance within 30 days of the invoice date. If your account becomes over 90 days past due you will be required to pay at your next session the outstanding balance in full in addition to your normal co-payment / co-insurance before services will be rendered. Please be aware if a balance remains unpaid, you may be discharged from therapy services.

9. Forms of Payment: Our office accepts the following forms of payment:

– Cash

– Check

– Credit/Debit Cards –Visa, MasterCard, AMEX, and Discover –if you choose to pay with a credit/debit card there will be a 2.75% surcharge added to the total payment.

Keystone Therapy Services is committed to providing the best therapy to our clients. Our prices are representative of the usual and customary charges for our area.

Thank you for reading and understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy and agree to abide by its guidelines:

____
Client Name

____ ____________________
Signature of Parent/ Legal Guardian Date