Patient Information

Carolina Therapy Services

Name (First) ____________ (MI) ______ (Last) ____________

Date Of Birth: ________ Age: ______ Sex: ☐ M ☐ F Marital Status ☐ S ☐ M ☐ W ☐ D

Address: (Street) ____________

(City, State, Zip) ____________

Phone #: ________ Work#: ________ Mobile# ________

Social Security Number: ________ Emergency Contact Name/Number: ________

Email adress: ____________

Guarantor/Responsible Party Information

Name (First) ____________ (MI) ______ (Last) ____________

Date Of Birth: ________ Age: ______ Sex: ☐ M ☐ F Marital Status ☐ S ☐ M ☐ W ☐ D

Address: (Street) ____________

(City, State, Zip) ____________

Phone #: ________ Work#: ________ Mobile# ________

Drivers License#: ________ Social Security Number: ________

Employer: ____________

Employer's Address: ____________

Primary Insurance Information

Insurance Co: ________ ID# ________ Group# ________

Insured's Name: ________ Relationship to patient ☐ self ☐ spouse ☐ dependent

Employer's Address: ____________

Insured's Social Security #: ________ DOB ________ ☐ M ☐ F

Secondary Insurance Information

Insurance Co: ________ ID# ________ Group# ________

Insured's Name: ________ Relationship to patient ☐ self ☐ spouse ☐ dependent

Employer's Address: ____________

Insured's Social Security #: ________ DOB ________ ☐ M ☐ F

I hereby assign, transfer, and set over to Carolina Therapy Services, Inc. all my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of my medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance

Guarantor Signature: ____________ Date: ____________

2013

NO-SHOW/CANCELLATION POLICY

We schedule our appointments so that each patient receives the right amount of time to be seen by our therapists. That is why it is very important that you keep your scheduled appointment with us and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, Carolina Therapy sends a text message reminder 1 day in advance of the appointment time.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to be scheduled, please give us at least **24 hours** notice. If a patient misses a scheduled appointment without notifying the clinic, it will be considered a no-show.

If **2 no-shows and/or two or more late/unexcused cancellations** occur within a calendar month, the patient will be placed on a "floating status" where the **caregiver will be responsible for calling to schedule weekly appointments within the clinic's availability**. It cannot be guaranteed that your child will see a specific therapist at a specific time once they are no longer in compliance with the No-Show Policy. Appointments will be offered on a first come, first serve basis.

Patient Name:_______________________________

Caregiver Signature:_____________________________

Caregiver Printed Name:____________________________

Patient, Parent, Caregiver Consent and Acknowledgement

Please initial each section and sign below.

______ Consent *for Treatment*: I consent and authorize treatment/care, as determined to be necessary, by Carolina Therapy Services, Inc. I am aware that the practice of therapy is not an exact science and I understand that no guarantees have been made to me about the results of treatments or procedures. I acknowledge that therapy may be provided in areas not totally isolated from other patients and personnel.

______ Notice *of Privacy Practices* is a complete description of the rights of patients at Carolina Therapy Services, Inc., with respect to patients' information and how patient information is protected. I have been given the opportunity to review the *Notice of Privacy Practices* prior to signing this Consent. I give permission to Carolina Therapy Services, Inc. to release information, in accordance the *Carolina Therapy Services, Inc. Notice of Privacy Practices.*

______ *Financial Responsibility*: I consent and authorize Carolina Therapy Services, Inc. to apply, file, and receive all medical insurance benefits, private/ primary/ secondary or all other benefits, for any and all services rendered. I agree that I shall be jointly and severally financially responsible for any portion of the Carolina Therapy Services, Inc. invoice that is not paid, including but not limited to (i) deductibles, co-payments, (ii) any non-insured services, or (iii) any charges in excess of payment limitations imposed by third party payors. I understand that a $25.00 processing fee will be charged for a returned check from my banking institution, and that after 3 returned checks, all payments will need to be made by cash, money order, or credit card.

______ *Digital Media and Electronic Communication*: I consent to digital media recordings (i.e., video, audio, photographs) and/ or electronic communication, including text and unencrypted emails, for the purposes of patient/parent/caregiver education, home exercise programs, treatment planning, diagnostic purposes, debt collection and/or internal training. If stored, the recordings will be located on password protected or encrypted company equipment.

______ *No Show/ Cancellation Policy*: I acknowledge the understanding of the *No Show/ Cancellation Policy*. Carolina Therapy Services, Inc. requests that I give at least a 24-hour notice, when cancelling an appointment. Two no-shows and/or two or more late/unexcused cancellations will result in the patient being placed on a "floating status". This status requires that the patient/parent/caregiver call and reschedule future appointments. These appointments will be offered on a first come, first serve basis. Carolina Therapy Services, Inc. does not guarantee a specific therapist, when on a floating status.

_____ *Pediatric Patients*: I acknowledge that a parent/ caregiver must be present (i.e.in the waiting room), throughout the therapy session. However, if the patient is 10 years or older and has no behavioral issues, drop offs are allowed. In addition, I acknowledge that I am responsible for my child outside of the therapy session.

______ *Rights and Responsibilities*: I acknowledge that I have been given the opportunity to review the *Carolina Therapy Patient Care Policy.*

Emergency Contact: Name: ______________________________ Phone Number: ______________________________

______________________________ ______________

Signature of Patient or Patient Representative Date

______________________________ ______________________________

Printed Name of Signature Above Relationship to Patient

FRP Policy

Carolina Therapy Services strives to ensure a clear understanding of your financial responsibility with respect to the medical services we provide. As of 9/1/22, our policy has been updated to reflect that patient's with a balance of $500 or higher, must set up a payment plan with CTS, or services will be placed on hold until balance is paid in full and/or below 60 days past due.

For payment plans, we offer a draft on the day services are rendered, weekly, or monthly. We also offer a patient portal where you can pay for you/your child's therapy online by entering their account number and name:
https://www.patientnotebook.com/carolinatherapyservices/Enhanced/StatementLookup/Home

By signing below, I acknowledge the updated FRP policy and agree to make co-pays at the time of service, or give Carolina Therapy Services the information needed to enroll in a payment plan. I understand that if my child's balance gets above $500, we are at risk for treatment being placed on hold.

Per information that we have received from your insurance company, your patient responsibility is listed below;

Deductible: ______________________________

Co-Pay:______________________________

______________________________ ____________________

Patient or Financially Responsible Person **Date**

______________________________ ____________________

Program manager **Date**