

NEW PATIENT INFORMATION

Date: _____

Patient: _____ DOB: _____

Mother/Guardian: _____ Home #: _____

Address: _____
City State Zip

Mother Social Security Number: _____ DOB: _____

Mother Employer: _____ Work #: _____ Cell #: _____

Father/Guardian: _____ Home #: _____

Address: _____
City State Zip

Father Social Security Number: _____ DOB: _____

Father Employer: _____ Work #: _____ Cell #: _____

Physician: _____ Phone #: _____

Responsible Party: _____ Home #: _____

Address: _____
City State Zip

Primary Insurance: _____ Group #: _____ ID #: _____

Insured Name: _____ Relationship: _____ DOB: _____

Secondary Insurance: _____ Group #: _____ ID #: _____

Insured Name: _____ Relationship: _____ DOB: _____

Family Email Address: _____

[] Yes, I would like to receive email notices including TherapyWorks newsletter, upcoming patient reward programs and special events. TherapyWorks will keep all information confidential and it will not be disclosed to any outside vendors.

[] No, I would not like to receive electronic communications. Verified By: _____

CONSENT TO TREAT

Patient: _____
(Please print full name)

Date of Birth: _____

I hereby authorize TherapyWorks, Inc. to perform occupational, physical and/or speech therapy evaluation, 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.

Insured/Guardian Signature: _____ **Date:** _____

RELEASE OF CONFIDENTIAL EVALUATION AND TREATMENT INFORMATION AND RECORDS TO AND FROM THERAPYWORKS, INC.

Notice to Patient: Your request for access to your protected health information is only applicable to the information maintained by the TherapyWorks, Inc. If you would like access to your protected health information maintained by any other Health Care Provider, a separate request must be submitted to that provider.

TherapyWorks, Inc. has my permission to release information about the above named patient and/or make contact with the following sources by whatever means necessary. (Source examples: your family, personal physician, health specialist, hospital, school or organization.)

Name: _____ Address: _____	Phone: _____ Fax: _____
Name: _____ Address: _____	Phone: _____ Fax: _____
Name: _____ Address: _____	Phone: _____ Fax: _____
Name: _____ Address: _____	Phone: _____ Fax: _____

I, the undersigned, do hereby authorize these sources to release medical, surgical and/or psychological reports from the patient's records. This information will be used for occupational, physical and/or speech therapy evaluation and treatment. The information should be sent to:

TherapyWorks, Inc.
7608 East 91st Street, Suite 100
Tulsa, OK 74133

I hereby declare that I have read and fully understand all of the information above. I do hereby agree that all said information is true and correct. It is understood that I may revoke this treatment consent or release at any time by written request except to the extent that action has already been taken. I fully understand and agree to all the terms outlined above.

Insured/Guardian Signature: _____ **Date:** _____



Authorization for Release of Medical Information/Records

Patient Name: _____ **Date of Birth:** _____

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

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.

By state law, you must be advised that: The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS).

Signature

Date

Guarantor Signature
(Authorized person if patient is unable to sign, or under 18 years of age)

Date

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



NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

We are committed to protecting the privacy of your medical information. We are required by law to maintain the confidentiality of information that identifies you and the care you receive. This Notice describes your rights and our legal duties regarding your Protected Health Information. "Protected Health Information," means any information about you that identifies you or for which there is a reasonable basis to believe the information can be used to identify you. In this Notice, we call that protected information, "health information." If you have any questions about this notice, please contact our Privacy Officer at (918) 663-0606.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your protected health information. All employees of TherapyWorks and any member of a volunteer group that provides help to patients must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We have the right to change this notice. We reserve the right to make the revised Notice effective for health information we already have as well as any information we receive in the future. Copies of the current Notice will be posted in the clinic. The effective date will be displayed on the front page.

QUESTIONS AND COMPLAINTS

If you would like more information about our privacy practices or have questions or concerns, please contact us. If you believe your privacy rights have been violated, please file a written complaint with TherapyWorks. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

Privacy Officer
7608 E. 91st Street, Suite 100
Tulsa, OK 74133
Phone (918) 663-0606
Fax (918) 663-8754

TherapyWorks supports your right to the privacy of your protected health information. You will not be penalized in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

USES AND DISCLOSURES OF HEALTH INFORMATION

We will use or disclose health information about you for therapy treatment, payment and healthcare operations including equipment vendors.

Treatment. We may use or disclose your health information to your physician(s) or other healthcare providers providing services to you.

Payment. We may use or disclose your health information to obtain payment for services we provide to you. Common payment activities include, but are not limited to, determining eligibility or coverage under a health plan, billing and collections.

Health Care Operations. We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Business Associates. We may disclose your health information to other entities that provide a service to us or on our behalf that requires the release of health information. We will only make these disclosures if we have received satisfactory assurance that the other entity will properly safeguard your medical information.

Example: We may contract with another entity to provide transcription or billing services.

Your Authorization. In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Your Family and Friends. We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Appointment Reminders. We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, postcards or letters.

Sign-in Sheet. We may use or disclose your health information by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Required by Law. We may use or disclose your health information when we are required to do so by law. *Example:* We are required by law to report criminally inflicted injuries and cases of abuse and/or neglect. We are also required by law to respond to a court order or other similar process.

Health Oversight Activities. We may disclose health information to a health oversight agency for activities necessary for the government to monitor the health care system, government programs and compliance with applicable laws. These oversight activities include, for example, audits, investigations, inspections, medical device reporting and licensure.

Persons Involved in Care. We may use or disclose health information to notify, or assist in the notification of, a family member or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Marketing Health-Related Services. We will not use your health information for marketing communications without your written authorization.

PATIENT RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. We will charge you a reasonable, cost-based fee for expenses such as copies and staff time. You may also request access by sending a letter to TherapyWorks. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. Any fees will be explained before copies are made to give you an opportunity to withdraw your request. Please contact TherapyWorks using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting. You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. For additional lists during a 12-month period, we may *charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw* or modify your request at that time before any costs are incurred.

Restrictions. You have the right to request that we place additional restrictions on our use or disclosure of your health information. You must make your request in writing. We are not required to agree to additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. *For example,* you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing. Your request must specify how or where you wish to be contacted. We will not ask you for the reason for the request. We will accommodate all REASONABLE requests.

Copy of This Notice. You have the right to a paper copy of this notice. Copies of this notice will always be available from our front office.

Amendment. You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

working wonders in children's lives

THE THERAPY WORKS

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

Acknowledgement of Receipt of Notice of Privacy Practices

A complete description of how your protected health information will be used and disclosed by TherapyWorks, Inc. is in our Notice of Privacy Practices, which you should read before signing this Acknowledgement. This Notice is posted throughout our office and you will be given a copy for your personal use.

I have received a copy of TherapyWorks, Inc. Notice of Privacy Practices dated April 14, 2003.

Signature of Patient or Representative

Patient Relationship

Date

Payment and Insurance Acceptance Policy

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 of 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 TherapyWorks calling and verifying 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 again if necessary. If, for any reason, your insurance company declines payment, you will be responsible for payment of all outstanding services that have been rendered.

We require a 24-hour cancellation notice. If notice is received less than 24 hours prior to your scheduled appointment time, a \$25.00 cancellation fee will be applied to your account. This fee also applies to missed appointments where no notice is given to our office. This fee must be paid at your next visit prior to seeing the therapist. Three (3) no-show appointments or five (5) cancelled appointments will result in all future appointments being removed from the schedule, at which time we will schedule you 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. Many non-covered items may include Medical Necessity, Developmental Delay, Ineligible for Coverage, or Non-Covered Benefit. The patient 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 ranking.

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

Patient or Guardian Signature

Date

Witness

Date