Therapeutic Potentials, Inc.
Patient Information

PATIENT: _____

DOB:_____ GENDER: MALE FEMALE

ADDRESS: _____ CITY/STATE/ZIP: _____

CELL PHONE: _____ ALTERNATE PHONE: _____

RESPONSIBLE PARTY: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

EMAIL: _____

EMERGENCY CONTACT PERSON: _____

RELATIONSHIP:_____CELL PHONE: _____

REFERRING PHYSICIAN: _____

CONSENT TO MEDICAL TREATMENT:

I, the undersigned, whether acting as parent, guardian, responsible party, or agent, voluntarily consent to therapy as determined to be necessary or beneficial in the professional judgment of my physician or therapist that falls within the scope of practice as defined by the State of Florida.

I acknowledge that no guarantees have been made to me as to the effect of such treatment on the patient's condition.

By signing this form, I acknowledge that I have read and understand the contents and that I am authorized to execute it on behalf of the patient.

_____

Name (Client, guardian, responsible party) *Please print* **Relationship**

_____

Signature (Client, guardian, responsible party) **Date**

Please Attach a Copy of Insurance Card, Drivers License Front and Back

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name:_____**DOB**:_____

*You May Refuse to Sign This Acknowledgement

I _____ have received a copy of this office's notice of Privacy Practices.

I authorize Therapeutic Potentials, Inc., to share Protected Health Information with the following person(s):

_____Relationship_____

_____Relationship_____

May we leave appointment information on your answering machine? YES NO

May we leave medical or billing information on your answering machine? YES NO

May we text appointment information to your cell phone? YES NO

May we email you appointment or billing information? YES NO

_____

Name (Client, parent, guardian, responsible party) *Please print* **Relationship**

_____

Signature (Client, parent, guardian, responsible party) **Date**

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____Individual refused to sign

_____Communication barriers prohibited obtaining the acknowledgement

_____An emergency situation prevented us from obtaining acknowledgement (Specify)

_____

_____

Staff Signature **Date**

Financial & Office Policy

Patient Name:_____DOB:_____

This Financial Policy will explain our billing policy and expectations. Please read it carefully. A copy will be provided upon request and a copy is kept with your billing records.

Payment is expected at the time services are rendered. I understand that I am responsible for all deductibles, coinsurance, copayments, maximum benefits denials, and/or non-covered services. A claim for services will be filed to the insurance company as a courtesy, however, all follow-up of unpaid claims will be my responsibility.

Assignment of Benefits:

I hereby authorize Therapeutic Potentials, Inc, to release information acquired, during the course of my examination and treatment, to Medicare, Medicaid, Medigap, and/or commercial insurance carriers, as necessary, to secure payment of any benefits due.

I hereby assign payment of benefits directly to Therapeutic Potentials, Inc, for any medical treatment performed and billed to Medicare, Medicaid, Medigap, and/or commercial insurance carriers. I understand that I am responsible for all charges regardless of insurance status as well as any associated costs for collection should such action become necessary. I agree that this authorization shall be valid until rescinded in writing or replaced on a future date. A photocopy of this agreement shall be considered as valid as the original. I have read and fully understand the terms above.

Balances remaining unpaid over 30 days may accrue interest in the amount of 1.5% of my balance each month (18% APR) and may be turned over to an outside agency for collection. I agree(s) that in the event of default or that the account is placed with a collection agency for collection, I am responsible for reasonable attorney's fees, collection agency fees, court costs, service charges, and/or interest as allowed by the law. In the case that legal action is instituted to collect such fees due to failure to pay on my part, I agree to pay in addition to the costs and disbursements provided by statute such that the court may adjudge reasonable attorney's fees in said action. In a divorce situation, as a parent, I am responsible for all charges incurred. Although a divorce decree may state that an ex-spouse is responsible for medical bills, Therapeutic Potentials, Inc,. has no authority to enforce compliance with such a decree and requires payment in accordance with this policy. Information about my account may be reported to credit bureaus. Late payments, missed payments, or other defaults on my account may be reflected in my credit report.

Therapeutic Potentials, Inc., reserves the right to discontinue all therapy services until delinquent accounts are satisfied.

Brief conferences as well as brief telephone conferences are considered part of the regular intervention program, and no additional charges will be made. There will be a charge for conferences with parents, physicians, tutors, or teachers that exceed 10 minutes in length.

If I must cancel a scheduled appointment, it is necessary that I give 24-hour advance notice. Except in the case of emergency or sudden illness, with the exception of Medicaid clients, appointments that are not canceled with a 24- hour advance notice will be charged as if a session was held. Medicaid patients who miss three scheduled appointments without a 24-hour advance notice (except in cases of emergency or sudden illness) will become ineligible to receive further services from Therapeutic Potentials, Inc. I understand that at various times of the year, my child's therapist may be away from the office. I will be notified in advance of the dates and a makeup session will be scheduled or a substitute therapist will be offered.

Returned check policy: A $50.00 fee will be charged to your account for all returned checks.

I have read and accept the above policies and authorize Therapeutic Potentials, Inc., to provide evaluation and therapeutic services for my child.

_____

Name (Client, parent, guardian, responsible party) *Please print* **Relationship**

_____

Signature (Client, parent, guardian, responsible party) **Date**