West Tennessee HEALTHCARE™ | Therapy & Learning Center

CLIENT INFORMATION:

Person completing form:_____ Date:_____

Client's Name _____
Last First Middle

Date of birth _____ Sex ___ Male ___ Female Social Security # _____

Race: ___ Black ___ Hispanic ___ Asian ___ White ___ Other:_____

Address _____
Street address Apt. #

_____
City State Zip County

Physician _____

Emergency contact: Name_____

Relationship_____ Phone _____

PARENT/GUARDIAN INFORMATION:

Name _____
Last First Middle

Date of birth _____ Sex ___ Male ___ Female Social Security # _____

Relationship to client: ___ Parent ___ Foster parent ___ Adoptive parent
___ Other family member with legal guardianship
___ Other: _____

Address: ☐ Same as client *or* ☐ Different from client, list below

_____
Street address Apt. #

_____
City State Zip County

Phone: Home _____ Work _____

Cell _____ Alternate _____

Email address:_____

Marital status: ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated

Employment status: ___ Full-time ___ Part-time ___ Not employed

Employer_____ Phone_____ Title_____

INSURANCE INFORMATION:

Primary Insurance:

Insurance Company: _____ Phone _____

Subscriber/ID # _____ Group/policy # _____ Effective date _____

Name of card holder _____ DOB: _____ SSN: _____

Relationship to client: ☐ Parent ☐ Step-parent ☐ Other family member with legal guardianship

Secondary Insurance:

Insurance Company: _____ Phone _____

Subscriber/ID # _____ Group/policy # _____ Effective date _____

Name of card holder _____ DOB: _____ SSN: _____

Relationship to client: ☐ Parent ☐ Step-parent ☐ Other family member with legal guardianship

☐ N/A - Local school district is payor for agreed upon therapy service(s)

SCHOOL REFERRALS: *(to be completed by LEA representative)*

Type of therapy requested: ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy

Service requested: ☐ Evaluation and treatment as recommended
☐ Evaluation only ☐ Treatment only

School attended: _____ Teacher: _____

School District: _____

LEA Representative Signature: _____ Date: _____

West Tennessee HEALTHCARE | Therapy & Learning Center

THERAPY & LEARNING CENTER

CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY

Client's Name:_____ DOB: _____

1. I consent for the client indicated to receive treatment/therapy services by the Therapy & Learning Center.
2. I consent to the release of all medical records to the referring physicians and to insurance company, if applicable. I allow fax or email transmittal of medical records, if necessary.
3. I agree that I will promptly notify the Therapy & Learning Center of any changes in insurance coverage, contact information, and other pertinent information.
4. I authorize payments to be made directly to the Therapy & Learning Center by insurance companies, TennCare, and other payor sources if applicable, for any covered services provided.
5. I agree to be financially responsible for payment. Although insurance may be assigned to and directly payable to the Therapy & Learning Center, I understand that any part of the account not paid by insurance is owing and payable. *Exception: Required services that are specified on an Individualized Family Service Plan (IFSP) or Individualized Educational Plan (IEP) in which the Therapy & Learning Center is the provider are at no cost to families.*
6. I understand that I am financially responsible for any deductible, copay or services not covered by insurance. *Exception: Required services that are specified on an Individualized Family Service Plan (IFSP) or Individualized Educational Plan (IEP) in which Therapy & Learning Center is the provider are at no cost to families.*
7. I consent to the release of any medical information necessary to process medical claims and request payment of medical benefits to the Therapy & Learning Center for services rendered.
8. I understand that accounts past due may be turned over to a collection agency.
9. By signing this document, I acknowledge that I have received a copy of West Tennessee Healthcare's Joint Notice of Privacy Practices.
10. In the event that services cannot be provided in person due to availability or by caregiver request, any evaluations, assessments, and therapies may be completed via a West Tennessee Healthcare approved video conferencing technology platform. By initialing _____, I am consenting to participate in a teleconference delivery of evaluation, assessment, and therapy. I understand that personally identifiable information, such as name or birthdate of my child, may be transmitted during use of video technology. I understand that I have the right to stop or refuse treatment related to teleconferencing at any time.
11. I have read and fully understand the above consent for treatment and financial responsibility.

_____ _____

Printed Name of Parent/Legal Guardian Date

_____

Signature of Parent/Legal Guardian

West Tennessee Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

West Tennessee HEALTHCARE | Therapy & Learning Center

HISTORY & INFORMATION FORM

Thank you for choosing the Therapy & Learning Center for your child's therapy needs. Please complete this questionnaire to help us provide very good care for your child.

Today's date: _____

Child's name: _____ DOB: _____

Name of person completing form: _____

Relationship to child: _____

What are your concerns about your child? _____

_____

_____

Medical History:

1. Please list your child's doctors: _____
2. Diagnosis : _____
3. Past surgeries? ☐ No ☐ Yes (please list date/type): _____

   _____
4. Recent hospitalizations? ☐ No ☐ Yes (please list date/reason): _____

   _____
5. Medications your child takes: _____

   _____
6. Any allergies? ☐ None know ☐ Yes (please list): _____
7. History of seizures? ☐ No ☐ Yes Date of last seizure: _____
8. Has your child had a vision test? ☐ No ☐ Yes Results: _____
9. Has your child had a hearing test? ☐ No ☐ Yes Results: _____
10. Do you have any concerns about your child's eating or nutrition? ☐ No ☐ Yes

    If yes, please explain: _____

Birth History:

1. Was your child born full-term? ☐ Yes ☐No If no, how many weeks? _____
2. Were there any problems during pregnancy, labor, or delivery: _____

   _____
3. How much did your child weigh at birth? _____
4. Was your child in the Neonatal Intensive Care Unit after birth? ☐ No ☐ Yes If yes, how long? _____
5. Did your child have any medical problems after birth? _____

   _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME (PLEASE PRINT):	Birth Date:	SS No.: (Last 4 digits only)
	Drivers License No. (only required if you are NOT requesting records in person):	
	E-Mail Address:	

Information Being Released by: Therapy & Learning Center

Release Records To:	Address:	City:	
	Telephone No.:	State:	Zip:

Purpose of Disclosure: ☐ Medical Care ☐ Insurance ☐ At the Request of the Patient
☐ Other, Please Explain:

Method of Disclosure: ☐ Paper ☐ Facsimile ☐ Other:_____
☐ E-mail: Secure/Encrypted or Unsecure/Unencrypted: Note if sending **unsecured/unencrypted** e-mail over the internet, there is some level of risk that the information could be read or otherwise accessed by a third party while in transit. Please initial here that you wish to send unencrypted:_____

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED:

Dates of Treatment:
☐ All dates including future records or ☐ Specific dates:_____

Choose from the following (please initial):
_____ All therapy records including previous and future records _____ Other (specify):

I understand that:

1. I may revoke this authorization in writing at any time, but if I do so, it will not have any effect on any actions taken by the facility releasing the information (hereafter referred to as "the facility") prior to the facility's receiving the revocation. Further details regarding the manner in which this authorization may be revoked may be found in the facility's Notice of Privacy Practices.
2. This authorization allows the facility to release the above indicated documents in my medical record, including those copies from other health care facilities and providers as requested. The released information may no longer be protected by federal privacy regulations and may be redisclosed.
3. Any disclosure of records concerning diagnosis and/or treatment of alcohol and/or drug abuse is covered by Title 42 CFR, and if there is any such information, I hereby authorize the release of information. This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.
4. The facility is hereby released from any liability and the undersigned will hold the facility harmless for complying with this authorization.
5. The facility will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization, except for research related purposes and as otherwise permitted under applicable law.
6. The authorization will expire at the end of treatment by T&LC or 12 months from the date signed, whichever time period is longest, unless I provide an alternate expiration date or event.
7. If the facility will use or disclose my protected health information for marketing purposes, the facility will not receive remuneration or compensation for such use or disclosure for marketing purposes unless the WTH Privacy Coordinator completes and signs the following statement:

I, _____ (signature of WTH Privacy Coordinator) hereby certify that the facility will receive remuneration or compensation for the use or disclosure of this patient's protected health information from _____ (fill in source of remuneration or compensation).

I have read and understood this authorization. I hereby authorize the release, use, and disclosure of the above-requested protected health information about me.

Not applicable _____ _____

Signature of Patient **Signature of Patient's Parent/Guardian**

_____ _____ _____

Date **Relationship to Patient** **Telephone Number**