phone: (919) 651-4293
fax: (919) 650-6816
www.carolinatherapy.associates
info@carolinatherapy.associates

PATIENT REGISTRATION

Patient Name:_______________________________________Date of Birth:_______________
Address: ____City:______________Zip:_________

Parent/Caregiver Name:____
Home # _____________________ Cell # _________________ Alternate #_________________
Email Address: ____
Emergency Contact:____
Relationship:_____________________________________ Phone #_______________________

Primary Pediatrician: _______________________________________ Phone #______________
Primary diagnosis:____________________ Secondary diagnosis:________________________

Is your child eligible for Medicaid or in the process of requesting Medicaid? ☐ **Yes** ☐ **No**
Medicaid Id #_____________________________ Date Coverage Began:______________________

Private Insurance Information

Insurance Company Name: ____
Subscriber ID: __________________________Group #_____________________________________
Primary Card Holder: _____________________________Primary Cardholder DOB:___________
Employer: ____
Insurance Billing Address: ____
Insurance Company Phone Number: ____

Daycare/School/CDSA Information:

Does your child have an IFSP? ☐ Yes ☐ No
If yes, child's service coordinator: __________________ Coordinator's Phone #_____________

Does your child have an IEP? ☐ Yes ☐ No
If yes, a current copy of your child's IEP is required.

Child's School/Daycare: ____
Current therapy services provided at school (include frequency):_________________________

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MEDICAL RELEASE FORM

Patient Name: ______________________ Parent/Guardian: ________________________

Carolina Therapy Associates is authorized to release or request any medical information which is necessary in providing therapy services for my child from the following agencies. Please indicate the name of the professionals or agencies who currently work with or have worked with your child.

Pediatrician: ____

Developmental Pediatrician: ____

Case Manager: ____

Other agencies/therapists: ____

Hospitals/Clinics/Health Departments: __________________________________

School System: ____

CDSA: ____

Social Worker: ____

Ophthalmologist/Optometrist: ____

Others: ____

In the absence of the parent/legal guardian, the following persons may be present during therapy sessions:

________________________ ____________________ ____________________

I acknowledge receipt of information between Carolina Therapy Associates and the above named facilities/agencies. I acknowledge receipt of the Notice of Privacy Practices and understand the conditions under which information will be used and disclosed. I understand that I can add to or remove the authorization of any person at any time in writing to Carolina Therapy Associates. This authorization will be in effect so long as the business relationship continues. This agreement shall renew itself annually unless otherwise terminated by either party.

Signature: _________________________________ Date:__________________

CAROLINA THERAPY ASSOCIATES CONSENT FORMS

Consent for Treatment	I give my consent for Carolina Therapy Associates personnel to provide consultation, evaluation, and treatment at the following sites: ☐ School ☐ Daycare ☐ Home ☐ Telehealth/Telemedicine
Consent for First Aid	I give permission for Carolina Therapy Associates personnel to provide first aid as needed to my child in case of an emergency. I also give Carolina Therapy Associates personnel permission to seek medical assistance in case of an emergency. I will not hold Carolina Therapy Associates liable for accidents that may happen in my absence.
Consent for use of Protected Health Information (PHI)	I consent for Carolina Therapy Associates to use the patient's Protected Health Information (PHI) for the purpose of providing treatment, payment of services, and for Carolina Therapy Associates' general healthcare operations purposes. PHI means for any information, including demographic information, created or received by Carolina Therapy Associates that relates to past, present or future health conditions; information that relates to the provision of health care; information that relates to past, present or future payment for the provision of health care services; and information that can be used to identify the patient.
Consent for Communication	I consent for Carolina Therapy Associates to communicate with me regarding the care of my child which includes information regarding payment, scheduling, and the progress of my child during the course of care with Carolina Therapy Associates. I understand that voicemail messages may be left on the phone numbers I have provided and give permission for electronic mail (email) to the addresses I have provided. I understand that Carolina Therapy Associates is unable to encrypt email messages and we cannot guarantee confidentiality with information shared over electronic communications including text, email, and voicemails.
Consent for Billing and Payment of Services	I authorize Carolina Therapy Associates to contact my insurance company to confirm benefits and release information necessary to process claims. I authorize payment directly to Carolina Therapy Associates for services rendered. I understand that I am responsible for any co-pay/co-insurance and /or deductible amounts associated with the patient's benefits. I understand that it is my responsibility to know my benefits and that verification of benefits by Carolina Therapy Associates is not a guarantee of payment.
Acknowledgment of Privacy Practices	I have viewed a written description of Carolina Therapy Associates' Notice of Privacy Practices regarding my Health Information Rights and am aware that I am entitled to or may request my own copy of these policies.

I , ___________________ (parent or guardian name) have read and fully understand the content of this consent. I understand I may withdraw this consent in writing. My withdrawal will not be effective for actions already taken by Carolina Therapy Associates. This consent shall be effective so long as the business relationship continues. The agreement shall automatically renew itself annually unless otherwise terminated by either party.

Signature: _____________________________________ Date:____________________

CAROLINA THERAPY ASSOCIATES POLICIES

Financial Policy	• Payment is due upon receipt of invoice. • A 3% late fee will be charged for all unpaid bills over 60 days past due. • All bills over 90 days past due will be sent to collections and the patient will be discharged from therapy services. • For same day cancellations or no-shows, a $40.00 fee will be charged • Any returned checks, or stop payment notices will result in a $25 fee in addition to the original fee. • A private pay rate will be charged for therapist to attend any IEP or other meetings/trainings related to the patient which are not billable to the insurance company.
Illness Policy	Please cancel your child's therapy under the following conditions: • Fever/Vomiting within the past 24 hours (child must be fever free for 24 hours without any fever reducing medications provided) • Highly contagious conditions including the flu, stomach virus, diarrhea, conjunctivitis (pink eye), head lice, ring worm, etc • Severe respiratory problems (ie: thick or excessive nasal discharge, severe coughing, etc) Please notify your therapist if: • Your child has been exposed to or contracted any contagious illnesses, for example, strep throat, fifth's disease, chicken pox, etc. • Other members of the household are experiencing the above symptoms and your child receives therapy services in the home
Attendance & Cancellation Policy	To ensure quality therapy services we have the following attendance/cancellation policies in place: • Please provide 24 hour notice if you need to cancel or reschedule your appointment • If your child is sick please let us know as soon as possible • A $40 missed appointment fee will be charged for no show visits or cancellations with less than 24 hour notice • Your child may lose their reserved therapy time if 3 appointments are missed without prior notice provided • For home visit appointments, an adult must be in the home at all times.
Insurance Billing Policy	Carolina Therapy Associates is pleased to file in-network insurance claims for your family. However this does not guarantee coverage. Your coverage is a contract between you and your insurance company. We will make every effort to verify your coverage, but this does not guarantee payment. Carolina Therapy Associates is currently in network with Blue Cross Blue Shield, Aetna, Cigna, and NC Medicaid • It is the family's responsibility to cover any non-payment of insurance claims for any denial given by your insurance company. Please review your insurance policy carefully as individual plans are subject to provisions including limitations and exclusions. • It is the family's responsibility to notify Carolina Therapy Associates if there are any insurance changes or secondary insurances and/or Medicaid. If we are not updated and the therapy claim is denied, the charges will become the responsibility of the parent. • For Medicaid patients Carolina Therapy Associates will apply for prior approval once we are notified that the patient has an active Medicaid number. We cannot guarantee retroactive authorization for Medicaid on any visits prior to notifying Carolina Therapy Associates of current Medicaid. Payment for these visits will remain the parent's responsibility.

By signing below you understand, agree and accept the terms of these policies:

Signature: ________________________________ Date: _____________

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NOTICE OF PRIVACY PRACTICES

Carolina Therapy Associates is committed to protecting the privacy of our patients. This includes any medical information or personal data that we keep in our office regarding our patients. We are required by HIPAA (Health Insurance Portability and Accountability Act) to provide you with this statement regarding our privacy policies, our legal duties, and your rights regarding your information.

- All patients will be required to sign a consent form authorizing Carolina Therapy Associates to provide evaluation and treatment. All information that is provided during the evaluation and treatment process is considered confidential by the employees and volunteers at Carolina Therapy Associates.
- Confidential information will be stored in a secure location away from public access.
- Anyone who has access to confidential information must sign a confidentiality agreement,
- Therapists and staff have access only to information required to complete their job responsibilities.
- Exchange and use of protected health information between Carolina Therapy Associates employees will be permitted for the purpose of treatment, payment or healthcare operations.
- All computers containing confidential information are accessed only via a password.
- By requesting or initiating email communications, patients/guardians agree to release Carolina Therapy Associates and its employees for any breach of confidentiality that may occur with information transmitted over the internet.
- Disclosure of protected health information outside of Carolina Therapy Associates is permitted only when you sign a written authorization. Any authorization for disclosure may be revoked at any time by notifying Carolina Therapy Associates in writing. The revocation will not affect any use of disclosures permitted by your initial authorization while it was in effect.
- Parents agree to notify Carolina Therapy Associates if there are any additions or changes to their insurance (including adding/changing insurance policies and/or applying for medicaid).
- Under the following specific conditions, disclosure of information outside of Carolina Therapy Associates is permitted and /or required by law without your specific authorization:

    A. If there is a medical emergency involving the patient's health or safety

B. When Carolina Therapy Associates is required by law to report instances of neglect and/or abuse of a child.

C. When Carolina Therapy Associates is required by law to disclose physician information due to an accident which would cause health risk to the other persons

D. When Carolina Therapy Associates authorizes research for the purpose of program planning and evaluation of services through the use of statistical information that cannot be linked to any individual.

E. When Carolina Therapy Associates is required by law in response to judicial proceedings and/or law enforcement inquires.

- Carolina Therapy Associates will not use your protected health information for marketing without your written authorization.
- Carolina Therapy Associates reserves the right to change this notice and the privacy practices described below at any time in accordance with the applicable laws. All patients will be notified of these changes prior to implementation. You may request a copy of our notice at any time.
- All patients have rights related to the use and disclosure of protected health information. Upon providing a written request you have;

A. The right to request that your record be designated as a "secure" file

B. The right to inspect and request a copy of your records

C. The right to request amendment of your record

D. The right to receive an account of disclosures that have occurred with your record

- Each disclosure of protected health information will be documented on the record. Carolina Therapy Associates will make every effort to secure any identifying information that is transmitted outside the organization.

Carolina Therapy Associates recognizes the importance of confidentiality, and your right to be fully informed of all regulations regarding protected health information. If you feel that your privacy rights have been violated, please contact our office at 919-949-0563. Or you may contact the US Secretary of Health and Human Services. Provision of services will not be affected by the filing of any complaint.

I have read and understood the information presented in this document.

Parent Signature: ___________________________________ **Date:** ________________