411 Summit Street
Schulenburg, TX 78956
Phone: 979.743.2108
Fax: 979.743.2109

Patient: _____

MRN: _____

DOB: _____

Patient Demographics

Patient Name: _____ **Circle One:** Male or Female

Date of Birth: _____ **Social Security Number:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Telephone: _____ **Cell:** _____ **Work:** _____

Preferred Contact method: ☐ **Phone Call** ☐ **Text** ☐ **Email**

EMERGENCY CONTACT INFORMATION:

Name: _____ **Relation:** _____

Telephone: _____

PARENT/GURADIAN INFORMATION: ☐ **Not Applicable**

Mother's/Guardian Name: _____

Home Phone: _____ **Cell:** _____ **Work:** _____

Email: _____

Father's/Guardian Name: _____

Home Phone: _____ **Cell:** _____ **Work:** _____

Email: _____

Primary Care Physician: _____ **Phone:** _____

Referring Physician: _____ **Phone:** _____

Reason for today's appointment: _____

☐ Received copy of insurance card
☐ Received copy of photo ID

Primary Insurance Carrier: _____

Policy ID Number: _____

Policy Holder Name: _____

Policy Holder DOB: _____

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Consent to Treatment – Healthcare Agreement

I voluntarily consent to receive medical and health care services provided by Beyond Therapy and the agency's therapists, associates, assistants, and other health care providers as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment and payment purposes only. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I acknowledge that Beyond Therapy may use health information exchange systems to electronically transmit, receive and/or access my medical information which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history, and other health care information.

I understand that this Consent to Treatment - Health Care Agreement will be valid and remain in effect as long as I attend or receive services from Beyond Therapy, unless revoked by me in writing with such written notice provided to each clinic I attend or from which I receive services.

Print Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

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Consent for Media Recording

I, the undersigned, do hereby grant or deny permission to Beyond Therapy to use the image and/or video of my child, _____, as marked by my selection(s) below. Such use includes the display, distribution, publication, transmission, or otherwise use of photographs, images, and/or video taken of my child for use in materials that include, but may not be limited to, printed materials such as brochures and newsletters, videos, and digital images such as those on the Beyond Therapy web site.

- ❑ Deny permission to use my / my child's image and/or video at all.
- ❑ Grant permission to use my / my child's image and/or video in the following ways (mark all that apply):
  - ❑ **Limited usage:** I want my / my child's image and/or video used within the Beyond Therapy setting only (not in the larger community).
  - ❑ **Limited usage:** I want my / my child's image and/or video used for educational materials only (not marketing). This could be either within Beyond Therapy or in the larger community. One example of this could be videos in parent education classes.
  - ❑ **Limited usage:** I want my / my child's image and/or video used on printed materials only (no digital or video use).
  - ❑ **Unrestricted usage:** I give unrestricted permission for my / my child's image and/or video to be used in print, video, and digital media. I agree that these images may be used by Beyond Therapy for a variety of purposes and that these images may be used without further notifying me. I do understand that my / my child's last name will not be used in conjunction with any video or digital images.

Print Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

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Authorization for Release of Medical Records

I, _____, authorize and request the disclosure of the following information:

- ☐ Progress Reports, Data, Treatment Notes (Medical, ABA, OT, ST, PT, Psychology)
- ☐ History and Physical
- ☐ Diagnostic Radiology Images and Reports
- ☐ Evaluation Reports (Medical, ABA, OT, ST, PT, Psychology)
- ☐ Treatment Recommendations
- ☐ Client Diagnosis and Learning Profile
- ☐ IEP

Information may be obtained from: _____
(clinic name, institution, and/or provider)

Information may be utilized by Beyond Therapy for the following purpose(s):

- ☐ Treatment Service Coordination
- ☐ Review of Records and Assessment
- ☐ Assessment and Evaluation
- ☐ Formulation of Care Plan

You may inspect or copy the protected health information to be used or disclosed under this authorization. This authorization may be revoked at any time by sending written notification to Beyond Therapy. Your notice will not apply to actions taken by the requesting person/entity prior to the date they received your written request to revoke authorization.

Print Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

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Clinic Policies

STATEMENT OF CONFIDENTIALITY

Beyond Therapy shall maintain all records of communication and client information on a secure server with security access meeting all HIPPA standards. An authorization to release medical records must be signed to authorize Beyond Therapy to communicate with any party (school, therapy, medical providers) specifically about your records. Confidential information will only be shared for the purposes of the services being rendered. When confidential information is transmitted orally, Beyond Therapy shall maintain a log of communication of this confidential information. Nondisclosure shall survive the termination of this service agreement being bound by HIPPA and all other regulations regarding client confidentiality. There are no exclusions to this policy. I understand Beyond Therapy's Privacy Practices and have been offered a written copy of such policy.

Patient Initials: _____

FINANCIAL POLICY

Invoices:

Beyond Therapy bills for services rendered via electronic mail. Invoices may be sent via standard mail upon request. Payment is due within ten days of invoice receipt.

Patient Initials: _____

Consent to Bill Insurance:

I authorize Beyond Therapy to bill and collect payment from my insurance company. A representative from Beyond Therapy has explained my insurance benefits to me, and we have discussed the amount, if any, that I will be responsible for paying for services rendered. I understand that the information provided by the Beyond Therapy representative regarding insurance benefits was obtained from my insurance company. It remains my responsibility to know and understand my policy and the covered benefits. Beyond Therapy will not be held responsible for incorrect information provided by my insurance company. I understand that I am responsible for all charges that are not covered by my insurance company, including, but not limited to co-pays, deductible, and coinsurance. I agree to notify Beyond Therapy immediately of any changes regarding insurance coverage, insurance benefits, and/or eligibility. I understand that I will be responsible for any charges incurred if I do not inform the agency regarding insurance changes.

Beyond Therapy may be in network or an out of network service provider for speech-language therapy and/or physical therapy services. If In network, Beyond Therapy will accept assignment of benefits for those services the insurance will cover. If it is not covered, the patient/responsible party will be invoiced for the cost of services. While your insurance may cover speech therapy, it may not cover some services related to specific diagnosis codes.

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Private/Self Payment:

Therapy services may be provided under a private payment agreement. Fees vary based upon services provided and level of medical complexity involved. Payment is due at the time service is rendered unless an alternate arrangement is approved by the Beyond Therapy office manager.

Speech-Language Pathology:
Articulation Evaluation Fee: _____
Language Evaluation Fee: _____
Other Evaluation Fee: _____
Therapy Fee: _____

Physical Therapy:
Evaluation Fee: _____
Therapy Fee: _____

Other Services:
Developmental Screening: _____
Tutoring: _____
Remote Observations: _____

Patient Initials: _____

ATTENDANCE

If it is necessary to cancel or change a scheduled appointment for a non-emergent reason, 24-hour advanced notice is required by calling or texting the provider or office manager. If the cancellation is not made in accordance with this policy, a $30 cancellation fee will be charged to your account. Insurance does not cover cancellation fees. Payment is required prior to the next scheduled appointment.

Patient Initials: _____

Emergency and unforeseen circumstances are recognized and understood. Call or text the provider or office manager as soon as possible to inform of cancellation. Cancellation fees are not assessed in these cases.

Patient Initials: _____

Failure to arrive for a scheduled appointment without providing notification will result in a $50 no-show fee charged to your account. Insurance does not cover no-show fees. Payment is required prior to the next scheduled appointment.

Patient Initials: _____

Consistent attendance is necessary to reach the desired outcomes outlined in the patient's plan of care. In the case of excessive cancellations (three within 90 days) and/or missing appointments without notification (two within 90 days), services may be terminated at the discretion of the provider/agency. Termination of services will also result in forfeiture of remaining scholarship funds if applicable.

Patient Initials: _____

Your signature indicates understanding and agreement to adhere to the above policies defined within this document. My signature also confirms that the information I have provided in this agreement are true and accurate to the best of my knowledge.

Print Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____