BETH INGRAM THERAPY SERVICES

Speech-Language Therapy • Occupational Therapy • Physical Therapy

602 Vonderburg Drive • Suite 201 • Brandon, FL 33511

FOR APPOINTMENTS CALL: (813) 653-1149 F AX: (813)654-6644 www.bethingram.com

PEDIATRIC PATIENT REGISTRATION FORM

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST)	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER - -	❑ MALE ❑ FEMALE
ADDRESS: NUMBER & STREET APT#		CITY STATE ZIP CODE	
HOME PHONE		E-MAIL ADDRESS	
REFERRED BY		PHYSICIAN PHONE NUMBER	
PEDIATRICIAN /PRIMARY CARE PHYSICIAN		PHONE NUMBER	

PARENT/LEGAL GUARDIAN

MOTHER'S/GUARDIAN'S NAME (LAST, FIRST)	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER - -
CELL PHONE NUMBER	CELL PROVIDER: ❒AT&T ❒ VERIZON ❒T-MOBILE ❒ BOOST ❒METRO PCS ❒ CINGULAR ❒ SPRINT ❒ VIRGIN ❒_____	
FATHER'S/GUARDIAN'S NAME (LAST, FIRST)	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER - -
CELL PHONE NUMBER	CELL PROVIDER: ❒ATT ❒ VERIZON ❒T-MOBILE ❒ BOOST ❒METRO PCS ❒ CINGULAR ❒ SPRINT ❒ VIRGIN ❒_____	

INSURANCE INFORMATION

PRIMARY INSURANCE	POLICY HOLDER'S NAME (LAST, FIRST)	RELATIONSHIP TO PATIENT
INSURANCE ID/POLICY NUMBER	GROUP NUMBER	
SECONDARY INSURANCE	POLICY HOLDER'S NAME(LAST, FIRST)	RELATIONSHIP TO PATIENT
INSURANCE ID/POLICY NUMBER	GROUP NUMBER	

I am an authorized beneficiary of the above insurance plan(s). I confirm that all of the above information is accurate and I agree to notify Beth Ingram Therapy Services of any changes.

_____ / / _____ _____

SIGNATURE DATE RELATIONSHIP TO PATIENT

PROFESSIONAL PHILOSOPHY

It is our desire to provide the highest quality of medical care to our patients and to do this in a professional and empathetic way. It is our intention to accomplish these goals through personalized care presented in a comfortable manner.

ATTENDANCE POLICY

Consistent attendance is essential for your child's progress in therapy. The time for your child's appointment has been exclusively reserved for you and your child. Regularly scheduled appointments occur on the same day and time each week. Frequent cancellations and/or two consecutive "no shows" may result in a loss of your appointment time or discharge from therapy. **PATIENTS MAY BE REMOVED FROM THE SCHEDULE IF UNABLE TO MAINTAIN 80% ATTENDANCE AND IS SUBJECT TO A WEEK-TO-WEEK APPOINTMENT STATUS AFTER TWO CONSECUTIVE MISSED APPOINTMENTS.** Therapy must be consistent in order to be beneficial. Parents are encouraged to observe therapy sessions in order to facilitate the carry-over of learned therapeutic techniques. **The parent/guardian must remain on site for the duration of a child's session in case of an emergency, toileting issues, etc.**

❒ I DO/DO NOT (circle one) authorize Beth Ingram Therapy Services to send email and /or voicemail message appointment reminders to confirm appointments, to send email evaluation reports or to send email billing statements.

❒ I DO/DO NOT (circle one) authorize Beth Ingram Therapy Services to send text message appointment reminders to me on my provided cell phone number. I understand text message charges from my cell phone provider may apply.

FINANCIAL RESPONSIBILITY POLICY

By signing below, you acknowledge that you have read, understand and agree to abide by the Patient Financial Policy terms. It is your responsibility to provide us with your correct and current insurance information at the time of your visit. You must inform us of any change in your insurance information once you receive notice of any coverage changes from your insurance carrier.

NOTICE OF PRIVACY PRACTICES

As a part of your child's care, Beth Ingram Therapy Services will originate and maintain paper and/or electronic records describing your child's health history, symptoms, evaluation and test results, diagnosis, treatment, and any plans for future care or treatment. The Notice of Privacy Practices that provides a description of Protected Health Information uses and disclosures has been provided to you. Beth Ingram Therapy Services reserves the right to change its Notice of Privacy Practices that will be effective for health information the clinic already has about you, as well as any received in the future. We will post a current copy of the Notice for your review. You may also obtain a copy of the current Notice in effect upon request.

PERMISSION FOR MEDICAL TREATMENT

Permission is hereby granted for therapists, employees or agents of Beth Ingram Therapy Services to render the patient named below medical treatment as deemed necessary. Such care may include, but not be limited to diagnostic evaluations and procedures considered advisable in the diagnosis, treatment and course of care. I understand that he/she will be expected to follow treatment plans that are mutually agreed upon between the treating clinician, primary care physician, and me.

I certify that I am the parent or legal guardian and that I can exercise all rights for said child. My signature below acknowledges that I have read all of the above and understand/agree to all provisions therein regarding attendance, responsibility for payment, permission for treatment and Notice of Privacy Practices.

PATIENT'S NAME: _____ _____
(Please Print) Date of Birth

_____ _____
SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

If Legal Guardian, relationship to patient: _____

CURRENT CONCERNS	
Reason for today's visit:	❒ Speech ❒ Language ❒ Gross Motor ❒ Fine Motor ❒Mobility ❒ Feeding ❒ Sensory Processing
Select any evaluations within the last six months?	❒ None ❒ Speech/Language ❒ Physical Therapy ❒ Occupational Therapy When? _____Where?_____
Describe your concerns:	
When was the problem first noticed?	
Describe any problems that appear to be a result of your child's difficulty:	
How do you and your family members react to this problem?	
What are your goals for treatment?	
Check any special equipment used by your child:	❒Wheelchair ❒ Braces ❒ Walker ❒ Eye Glasses ❒ Hearing Aids ❒Communication Device ❒Other _____
Does your child have any pain?	❒ NO ❒ YES If yes, where: _____
Describe the pain:	❒ Sharp ❒ Dull ❒ Ache ❒ Pins and needles
Frequency of Pain:	❒ Constant ❒ Comes and goes ❒ Morning ❒ Night ❒ With Activity
Sensory Aversion/Triggers:	_____❒ None
FAMILY BACKGROUND	
What is the primary language spoken in the home?	❒ English ❒Spanish ❒ Creole ❒ Arabic ❒ Other _____
What is the child's dominant language?	❒ English ❒Spanish ❒ Creole ❒ Arabic ❒ Other _____
Other children in the family:	Name Age
Are there any family members or relatives who have or have had the same problem?	❒ NO ❒ YES If yes, who and what kind?

BIRTH HISTORY		
Were there any illnesses or complications during pregnancy with this child?	❒ NO ❒ YES If yes, explain?	
Pregnancy term and birth weight:	Full Term: ❒ YES ❒ NO If no, how many weeks?	Birth Weight:_____
Delivery Method:	Via: ❒ C- Section ❒ Vaginal ❒ Breech	
Were there any drugs or medications taken during this pregnancy?	❒ NO ❒ YES If yes, explain?	
Were there any immediate problems following the birth or during the first 2 weeks of the infants life?	❒ NO ❒ Jaundice ❒ Surgery ❒ Feeding ❒ Required Oxygen ❒ Sucking or swallowing problems ❒ Sleep patterns	

MEDICAL HISTORY			
How is your child's overall health?	❒ Good ❒ Fair ❒ Poor		
Are immunizations up to date?	❒ YES ❒ NO		
Does your child have any known allergies?	❒ None ❒ Yes If yes, please list:_____		
List all medications and dosages currently prescribed for the patient	MEDICATION	DOSAGE	PURPOSE
Does your child have a history of surgery/ hospitalization?	❒ NO YES If yes, please explain?		
How would you characterize your child's diet?	❒ Regular All foods allowed: no known food allergies or dietary restrictions ❒ Regular With exceptions: List food allergies/dietary restrictions: _____ ❒ Pureed (requiring very little chewing ability) ❒ Mechanical Altered (requiring some chewing) ❒ Advanced (soft foods that require more chewing ability		
Please check the following as they apply to your child:	❒ Autism/PDD/Asperger ❒Down Syndrome ❒Dyslexia ❒ Learning Disability ❒ Psychological /behavioral issues	❒ADHD/ADD ❒ Cerebal Palsy ❒ Hearing Loss ❒ Birth Defects ❒ None	
Has your child had any of the following conditions?	❒ Asthma ❒ Low birth weight ❒ Cleft Lip ❒ Cleft Palate ❒ Seizure Disorder ❒ Food Sensitivities ❒ Spinal cord injury	❒ Sprains ❒ Strains ❒ Spasms/Cramps ❒ Fractures/broken bones ❒ Degenerating Joints ❒ Head Injury ❒ Nerve injury	❒ Gastric Reflux ❒ Diabetes ❒ Adenoidectomy ❒ Tonsillitis ❒ Pneumonia ❒ Visual Impairments ❒ Juvenile Arthritis
Please describe any other relevant medical diagnosis:			

EDUCATIONAL BACKGROUND

Age at entrance to school: _____ **years** _____ **months**	❒ N/A ❒ Preschool ❒ Home Daycare ❒ Kindergarten Current school: _____ Grade: _____ Grades Repeated: _____
Type of classroom	❒ Regular ❒ Exceptional Student Special Program _____
Does your child have an IEP?	❒ NO ❒ YES Program: _____
Indicate any/all areas of difficulty:	❒ Reading ❒ Math ❒ Spelling ❒ Handwriting ❒ Writing sentences ❒ Interacting with others

BEHAVIORAL BACKGROUND

Please check as they apply to your child:

	YES	NO		YES	NO
Friendly/Outgoing			Mostly quiet		
Is usually happy			Poor Memory		
Is frustrated easily			Impulsive/Restless		
Poor turn taking skills			Difficulty concentrating		
Poor eye contact			Lacks pretend play		
Sleeping Difficulties			Avoids group play		
Attentive			Recognizes danger		
Cooperative			Avoids eye contact		
Eating Difficulties			Withdrawn		
Destructive/Aggressive			Overly active		
Thumb/finger sucking habit					
Exhibits difficulty learning new tasks					
Imitates actions / speech					
Difficulty with transitions/Resistant to change					
Difficulty separating from parent					
Self- stimulation/ self-injury					
Plays with toys appropriately					
Understands praise/punishment					
Plays alone for reasonable amount of time					

HEARING

Has the patient's hearing ever been tested?	❒ NO ❒ YES If yes, Where? When? By whom? What were the results/recommendations? _____
How many ear infections has your child had?	❒ None ❒ 1-2 ❒3-5 ❒ 6-10 ❒ 10 or more
Has your child worn Pressure Equalization Tubes (PE Tubes)?	❒ NO ❒ YES Which ear(s): _____ How Long? _____
Does your child have a diagnosed hearing impairment?	❒ NO ❒ YES If yes, Where? When? By Whom? Is the loss in one or both ears? What is the level of loss? _____
Does your child wear hearing aids?	❒ NO ❒ YES If yes, which ear(s) are the aids worn? _____

SPEECH/LANGUAGE SKILLS	
How does your child communicate his/her wants and needs:	❒ Looking at objects ❒ Complete Sentences ❒ Sounds/Grunting ❒ Conversations ❒ Pointing/Gestures ❒ Picture Symbols, PECS ❒ Single Words ❒ Augmentative/Alternative communication device ❒ 2-4 Word Phrases ❒ Sign Language
Which of the following best describes your child's speech	❒ Too young to talk ❒ Does not use words ❒ Gestures more than words ❒ Easy to understand ❒ Difficult for family to understand ❒ Difficult for others to understand
How much of the child's speech do you understand?	❒ 0% ❒ 10% ❒25%❒ 50% ❒75% ❒100% Does speech improve with repetition? ❒ NO ❒ YES
Estimate how many words are in your child's vocabulary:	Expressive (Speaking Vocabulary): ❒ Under 25 ❒ 25-75 ❒ over 75 Receptive (Understanding Vocabulary): ❒ Under 25 ❒ 25-75 ❒ over 75
Indicate with a check mark any/all areas of difficulty:	❒Pronouncing a variety of sounds (articulation) ❒ Describing events ❒Expressing thoughts /Making requests or needs known ❒Understanding what you are saying ❒ Speaking fluently (Stuttering) ❒ Answering yes/no questions ❒ Answering who/what/where/ when/why questions ❒ Following simple directions ("get your shoes" or "close the door") ❒ Recognizing/pointing to common objects
Does your child :	Repeat sounds, words or phrases over and over ❒ YES ❒ NO Need directions repeated often ❒ YES ❒ NO Have difficulty getting along with peers or prefers playing by self ❒ YES ❒ NO Have a hard time making connections with familiar people ❒ YES ❒ NO Function best in a small group or individually ❒ YES ❒ NO Wanders aimlessly without purposeful play or exploration ❒ YES ❒ NO Play with same toy for hours or watch same movie over and over ❒ YES ❒ NO Engage in meaningful conversation or communicate with intent ❒ YES ❒ NO
Did your child: **Babble/Coo by age 4 months** **Respond to name by 8 months** **Peek-a-boo by 8 months** **Imitate sounds by 12 months** **Use jargon by 12 months** **Say first words by 15 months** **Combine 2 words by 2 years** **Use short sentences by 3 years**	❒ YES ❒ NO If no, age in months _____ ❒ N/A ❒ YES ❒ NO If no, age in months _____ ❒ N/A ❒ YES ❒ NO If no, age in months _____ ❒ N/A ❒ YES ❒ NO If no, age in months _____ ❒ N/A ❒ YES ❒ NO If no, age in months _____ ❒ N/A ❒ YES ❒ NO If no, age in months _____ ❒ N/A ❒ YES ❒ NO If no, age in months _____ ❒ N/A ❒ YES ❒ NO If no, age in months _____ ❒ N/A
If your child stutters, complete the following:	Age stuttering began: _____ When is stuttering more frequent? Is the child aware of disfluencies? ❒ NO ❒ YES

GROSS AND FINE MOTOR SKILLS

Does your child lose their balance or fall easily?	❒ YES ❒ NO
Indicate with a check mark any/all areas of difficulty:	❒ Zippers/Buttons ❒ Hopping/jumping ❒ Dressing ❒ Handwriting ❒ Lacing/tying shoes ❒ Walking backwards ❒ Torticollis ❒ Accepting weight into legs ❒ Pulling to sit/stand ❒ Walking up/down steps ❒ Building tower with blocks ❒ Balancing ❒ Rolling over back to stomach ❒ Rolling over stomach to back ❒ Standing at furniture ❒ Throwing ball overhand ❒ Sitting Alone ❒ Standing Alone ❒ Walking/Running/Jumping ❒ Creeping on hands and knees ❒ Bearing weight on arms ❒ Bringing hands together at midline ❒ Transferring objects from hand to hand ❒ Lifting head while on stomach
Did your child: **Hold his/her head up by 4 months** **Sit alone by 6 months** **First walk alone by 16 months** **Potty-trained by 3 years** **Feed self by 2 years** **Use scissors by 3 years** **Grasp crayon/pencil by 3 yrs**	❒ YES ❒ NO If no, age in months _____ ❒ N/A ❒ YES ❒ NO If no, age in months _____ ❒ N/A ❒ YES ❒ NO If no, age in months _____ ❒ N/A ❒ YES ❒ NO If no, age in months _____ ❒ N/A ❒ YES ❒ NO If no, age in months _____ ❒ N/A ❒ YES ❒ NO If no, age in months _____ ❒ N/A ❒ YES ❒ NO If no, age in months _____ ❒ N/A

SENSORY MOTOR SKILLS

Please answer the following statements:

	Always	Sometimes	Never
Does your child seem overly awkward, uncoordinated or clumsy (poor body awareness)?			
Is your child overly sensitive to or extremely bothered by lights /sounds?			
Often sits in a "W sit" position on the floor to stabilize body.			
Has difficulty telling the difference between similar printed letters or figures; i.e., p /q, b /d, + / x, or square/rectangle			
Does your child avoid eating certain food textures/temperatures?			
Irritable when being dressed; uncomfortable in clothes.			
Is not bothered by injuries. Does not notice pain or is slow to respond when hurt.			
Is not aware of being touched/bumped unless done with extreme force or intensity.			
Has a hard time seeing the "big picture"; i.e., focuses on the details, background noises.			
Rocks body, shakes head/arms while sitting.			

BETH INGRAM THERAPY SERVICES FINANCIAL POLICY

Patient Name: _____ **Date:** ____/____/____

Thank you for choosing Beth Ingram Therapy Services to provide you with your therapy needs. We are pleased to participate in your care and look forward to providing you with world class therapy services. As part of this relationship, we wish to establish expectations of your financial responsibility as outlined in our Financial Policy. *Your medical insurance is a contract between you and your insurance company. We can help with providing information related to outpatient therapy services but you are primarily responsible for all charges that are incurred as a patient with Beth Ingram Therapy Services.* Please review this information and sign prior to your initial visit with our office.

Payment Responsibility I understand as a recipient of medical care I am responsible for all charges regardless of my circumstances for reimbursement. I understand it is my responsibility to be aware of the requirements and limitations of my own insurance plan benefits. I understand there is a fee charged for all visits, examinations, treatments, and medical reports. Co-pays and/or co-insurance are due at the time of service. I agree to provide Beth Ingram Therapy Services with complete and accurate information, including but not limited to; picture identification, current insurance card, a referral or authorization for visits or procedures if required. We are required to update this information on an annual basis, at minimum. I agree to pay for any service, supply, or visit that my therapist deems necessary if not paid by my insurance. **During the course of treatment if my or my child's insurance or benefits become inactive or discontinued for any reason, I agree to continue services for myself or my child at the agreed upon self pay rate.**

Insurance Verification: As a courtesy to our patients, we complete an investigation of benefits for therapy services. It is the patient's responsibility to verify coverage, understand their particular insurance benefits and ensure that payment is made. In the information attached we are **ESTIMATING** the amount you will need to pay for therapy services. Insurance verification is not a guarantee of payment and we encourage you to contact your insurance company to better understand your benefit for therapy services. If payment is for any reason denied you will be responsible for the amount your insurance company deems is patient responsibility.

Non-Covered Services: Insurance does not pay for all of your healthcare costs; some items and services are considered "non-covered benefits" under your health insurance plan and as such, your insurance will not pay for these services. Should you choose to receive these services; you will be personally responsible for the payment of such services. Once a determination has been made that the therapy services recommended are "non-covered benefits" under your plan, you may be eligible to participate in our Self-Pay plan and receive a discount on services.

Self-Pay In order to make our services accessible for people not covered by insurance, those who have an insurance policy with no out of network benefits, those whose insurance does not cover therapy services, or those whose insurance benefits have been exhausted for the year, we offer a self-pay plan. Charges are reduced by 20% for evaluations and an average of 40% per therapy visit (varies based on type of therapy required). Payment in full is due at the time of service unless an election is made to participate in one of the company's automated payment programs for recurring bank or credit card transactions. If a self-pay patient fails to make more than two (2) consecutive scheduled payments then the Self-Pay Plan will be forfeited and the patient will be obligated to pay the full standard rate for services rendered.

Missed Appointment Policy I understand the outcome of treatment depends highly on keeping scheduled appointments that are reserved. Beth Ingram Therapy Services reserves the right to charge $25.00 for missed appointments or cancellations without a 24-hour advance notice. If three scheduled appointments are missed my chart may be administratively closed and future sessions discontinued. Should this become necessary I will receive written notification as well as my referring physician, and insurance company (if required).

Returned Checks There is a $25.00 charge for any returned check in addition to the original amount of the check. This must be paid by cash, certified funds, or credit card prior to any additional visits.

Delinquent Accounts If your account becomes over 90 days past due with nonpayment, we will take the necessary steps to collect this debt. You will receive a letter stating you have 10 business days to pay your account in full. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency. If we have to refer your account to collections you agree to reimburse us the fees of any collection agency, which will be added to your account when it is place with a collection agency, and may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts. .

Method of Contact I agree that in order for Beth Ingram Therapy Services to service my account or to collect any amounts I may owe, Beth Ingram and their agents and affiliates may contact me by telephone at any telephone number associated with my account or any of my telephone numbers they may discover, including wireless telephone numbers, and that such contacts could result in charges to me. I agree that methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automatic telephone dialing system, as applicable, e-mails, text messages, and facsimiles.

Statement of Confidentiality I authorize the release of necessary medical information to Beth Ingram Therapy Services for the purpose of processing this or any related insurance claims. I also give Beth Ingram Therapy Services the authority to make available any requested documents contained in my file to myself and/or other health care providers involved in the treatment of my condition.

Assignment of Benefits I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Beth Ingram Therapy Services for any services provided to me.

Medicare I understand that as a Medicare beneficiary, I have a maximum benefit for outpatient physical therapy services. Beth Ingram Therapy Services will monitor your visits and make you aware as you near the maximum allowed by Medicare. I am responsible to make Beth Ingram aware of any previous treatment I may have had at another facility in the past 12 months. Medicare will not pay for outpatient therapy services while you are receiving home services. It is my responsibility to make sure my home health agency has discharged me for their care. I understand that I am responsible for full payment on any services provided over the maximum allowed amount.

Acknowledgement I understand that as part of my care, Beth Ingram Therapy Services will originate and maintain paper and/or electronic records describing my health history, symptoms, evaluation and test results, diagnosis, treatment, and any plans for future care or treatment.

By signing this document, I also acknowledge that I have received and understand a copy of the organization's Notice of Privacy Practices. This acknowledgment is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights and privileges.

***I have read the financial policy and agree to its terms. All questions have been answered prior to my signing this policy.**

_____ ____/____/____

Signature of Parent/Legal Guardian Date

_____ _____

Print Name Relationship to Patient

AUTHORIZATION FOR OTHER INDIVIDUAL TO ACCOMPANY MINOR CHILD

PLEASE COMPLETE THIS FORM IF ANYONE OTHER THAN THE LEGAL GUARDIAN WILL BRING THE CHILD TO THE EVALUATION OR THERAPY APPOINTMENT(S)

A parent or legal guardian must accompany a child younger than 18 years of age to consent for all medical treatment provided by Beth Ingram Therapy Services. It may be more convenient to have prior authorization so that medical care may be delivered directly to minors if a parent or legal guardian is not present prior to or during treatment. Please review the following authorization for treatment and complete the information if you want to authorize another individual to accompany your child for treatment.

AUTHORIZATION FOR OTHER INDIVIDUAL TO ACCOMPANY MINOR
I have the legal right to preauthorize this facility to deliver medical treatment to:

_____ _____/_____/_____
PATIENT'S NAME DATE OF BIRTH

I, undersigned, as the parent or legal guardian herby authorize Beth Ingram Therapy Services to provide diagnostic and/or therapy treatment of my minor child. I understand that I am financially responsible for all non-covered medical expenses incurred by my child during these appointments. The following individual(s) may also receive diagnostic results and additional information pertinent to the care and treatment of my child:

I authorize _____ _____
Name of person(s) being authorized Relationship to Patient

This authorization is valid from _____/_____/_____ to _____/_____/_____.
This consent will be valid for one year from the date of signature unless stated differently.
I understand I may revoke this consent any time in writing.

_____ _____/_____/_____
PARENT/LEGAL GUARDIAN SIGNATURE DATE

_____ (_____)_____
PRINT NAME CELL PHONE NUMBER

BETH INGRAM THERAPY SERVICES
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AUTHORIZATION FOR RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Please complete this form if you consent to the release of your child's medical records to the person(s) named below.

PATIENT NAME: _____ DOB: _____

This form is used to release or disclose Protected Health Information (PHI) as required by state and federal laws. Your authorization allows the release of your PHI to the individual or organization that you choose.

I_____ **(print name)** authorize the use or disclosure of personal and protected health information as described below:

☐ Complete Records: Any and all personal and protected health information.

Or Check all that apply

☐ Evaluation Reports ☐ Treatment notes ☐ Progress Summary ☐ Discharge Summary
☐ Billing Records ☐Plan of Treatment ☐ Attendance in treatment (Admission and discharge dates)
☐ Other: _____

The purpose of this release of information:

☐ Provide continuity of patient care ☐ Coordinate treatment ☐ Personal use ☐ Educational
☐ Attorney/Legal ☐ Other: _____

NOTE: This consent form allows personal and protected health information to be shared via telephone call with the individual or organization being authorized.

The information may be released to the following:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

RIGHT TO REVOKE: Your authorization is voluntary and may be revoked at any time by submitting a request in writing except to the extent that action has already been taken in response to this authorization.

EXPIRATION: This authorization will expire on _____. *If no date is specified, this authorization will expire twelve (12) months from the date it was signed.*

CONSENT: I authorize the use or disclosure of personal and protected health information described above to the individual(s) or organization(s) identified above. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

_____ _____/_____/_____
Signature of Patient/Parent/Legal Guardian Date

Legal Guardian Relationship to Patient: _____