ADVENT THERAPY
Physical•Occupational•Speech Therapy

10144 Ford Avenue, Richmond Hill, GA 31324
p: 912.727.2321 * f: 912.445.0599 *
www.AdventTherapyRH.com

Patient Name: _____

Please read and initial each item:

_____ CONSENT TO TREAT
I give consent for Advent Therapy to perform reasonable and necessary medical examinations, testing and / or treatment.

_____ RELEASE/ REQUEST
Permission is given to Advent Therapy to release and/or request information when necessary for the records of the above named individual to:

_____

_____

_____

_____ INSURANCE AUTHORIZATION/ASSIGNMENT
I allow my insurance company to be billed and I request that payment of authorized benefits be made directly to Advent Therapy for any services finished to me by that provider. I authoriace release of any information to my insurance company required in the course of treatment that may be used to determine benefits payable under my insurance plan.

_____

Signature Date

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INSURANCE/ PAYOR INFORMATION

Patient's name as it appears on policy: _____DOB:_____

Patient's Address: _____Sex: _____

Patient's Phone: Home_____Cell: _____email:_____

_____

Reason for Visit: _____

PRIMARY INSURANCE

Insured's Name: _____ Insurance Co.: _____

Member ID number: _____ Insured DOB: _____

Relationship to the patient: _____

SECONDARY INSURANCE

Insured's Name: _____ Insurance Co.: _____

Member ID number: _____ Insured DOB: _____

Relationship to the patient: _____

I certify that the information given by me in applying for payment is correct. I hereby authorize payment by my insurance carrier of the benefits, otherwise payable to me, to be made directly to Advent Therapy for their services.

I understand and agree that I am financially responsible for all co-pays, coinsurance and amounts not covered by my healthcare provider.

_____

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Attendance Policy

In order to maximize the benefits of therapy, it is very important that all scheduled appointments be attended. The consistency of attending therapy sessions assures that the patient will obtain maximum treatment benefit and assist in meeting his/ her goals. A " no show", "cancellation" or "late" appointment disrupts therapy schedules that impact both you and your therapist.

Please initial each of the following and sign at the bottom indicating that you understand and agree to our attendance policy.

_____ **No Shows:**

A no show is any missed appointment without a phone call to cancel the appointment. After three no shows, not rescheduled or made up, the patient may be taken off the therapy schedule.

_____ **Cancellations:**

A cancellation is any appointment canceled within 24 hours notice. Any appointment that is rescheduled within the same week does not count as a cancellation. If your attendance falls below 75%, there is a possibility that your therapy time may be offered to someone else.

No show and cancellations (less than 24 hour notice) with the exception of illness/emergencies will incur fees of $30 for Speech Therapy, $60 for Physical Therapy and $60 for Occupational Therapy. If multiple therapies are missed in one day, maximum charge is $100 per patient, per day.

Signature Date

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ACKNOWLEDGEMENT OR RECEIPT OF PRIVACY POLICIES AND PRACTICES

I, _____, have received a copy of Advent Therapy's Notice of Privacy Policies and Practices and authorize use and disclosure of my health information for treatment, payment, and health operations.

_____
Patient's Name

_____
Signature Date

CHILD ILLNESS POLICY

Please keep your child home from therapy under the following conditions:

- Fever/Vomiting within the past 24 hours (this includes a low grade temperature)
- Highly contagious conditions, including but not limited to the Flu, Stomach Virus, Diarrhea, Conjunctivitis (Pink Eye), Head Lice, or Ring Worm
- Severe Respiratory Problems (i.e. thick or odd-colored nasal discharge, severe coughing)

Signature: _____ Date: _____