Today's Therapy Solutions

2828 NW 57th St, STE 100 OKC, OK 73112
Phone: (405) 286-3749 Fax: (866) 435-3297
www.todaystherapysolutions.com

CLIENT INFORMATION: Today's Date _____

Name _____ Date of Birth_____

Address_____ City_____ State/Zip_____

Phone Number (home) _____ (work/cell) _____

Email _____

Primary Contact _____ Phone number _____

Emergency Contact_____ Phone number_____

PHYSICIAN INFORMATION

Name _____

Phone _____ Fax_____

Address_____City/State/Zip_____

What type of services are needed? (check all that apply)

☐ Speech Therapy ☐ Occupational Therapy ☐ Behavior Therapy

PAYMENT POLICIES (Please check ALL which apply)

☐ **SOONERCARE ONLY:** Our office will process your child's claims directly to Medicaid. **It is your responsibility to obtain a prescription and clinical notes from your doctor for services requested and provide us with a current IEP (if applicable). You must also keep us informed of any changes in your child's status (Medicaid coverage/change of physician) and will incur costs with a lapse in coverage.**

Name as printed on Soonercare Card _____ Soonercare Number_____

☐ **PRIVATE INSURANCE:** Our office will process claims to your insurance company first. If you have Medicaid secondary, we will then process the remittance from your private insurance to Medicaid.

Insurance Company_____ Name of policy carrier _____
Insurance ID#_____ Group #_____

☐ **PRIVATE PAY**: You may give us credit card information to run the Monday following each appointment or an invoice can be sent to you weekly. **If more than two appointments go unpaid, services will be placed on hold until the account is current again.** Please fill in the credit card information below if you would like your card to run automatically. Receipts can be sent via the following (please circle one): EMAIL MAIL

Credit Card Number _____ Card Type Visa Mastercard Discover
Credit Card Expiration _____ Name on Card_____

_____ _____
Signature of Guardian/Insurance Carrier Date

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Consent for Evaluation and/or Treatment

I consent to the evaluation and/or treatments of _____ (patient name) _____ (patient date of birth) at Today's Therapy Solutions (TTS) and authorize the qualified personnel thereof to perform such diagnostic procedures and administer such care and treatments as may be directed by the clinic policy or ordered and/or prescribed by the clinical staff person who is responsible for my child's care.

I acknowledge that I have been fully informed of evaluation procedures; care and treatment of my child, and any risks associated with it have been addressed to my satisfaction. I understand that I may be asked to participate in my child's therapy/ evaluation.

I understand that the professionals at TTS are required by law to report reasonable suspicions of child maltreatment. I understand that if I or my child is in danger of hurting ourselves and or others, this information may be reported in order to obtain proper protection. I understand that professionals and staff of TTS will keep records and information regarding my child's treatment confidential, except as authorized by me, as required by law, or as needed to protect persons from harm and to respond to reasonable suspicions that harm has occurred. I understand that TTS staff and professionals may share information among themselves for the purposed of coordinating care and for the other purposes necessary to carry out these activities.
I give permission for the person who brings my child for an evaluation and/or treatment to provide and to receive information concerning him/her.

I understand that the professionals and staff of TTS, when services are billed to a 3rd party insurance provider, will contact and provide information to my insurance carrier in order to obtain payment for evaluation and/or treatment , and to document my child's evaluation results, treatment plan (if any), and diagnosis (as required by applicable contracts). I understand that payment or co-payment, if applicable is due at the time of service, unless other arrangements have been made in advance.
The information in this form has been discussed with me. I have been given the opportunity t ask any questions I have regarding this consent. I am legally authorized to consent to the services provided by TTS for the above-named child patient.

_____	_____	_____	_____
Patient DOB	**Patient Name**	**Patient Signature**	**Today's Date**

_____	_____	_____
Parent or Guardian Name	**Parent or Guardian Signature**	**Today's Date**

_____	_____	_____
Relationship to Patient	**Witness**	**Today's Date**

Today's Therapy Solutions

Today's Therapy Solutions Court Appearance Fee Agreement

Today's Therapy Solutions (TTS) is a health facility where our employees serve a large number of clients just as a medical facility does. Today's Therapy Solutions' clients see their counselor, occupational therapist, speech therapist and/or neuropsychologist by appointment. While Today's Therapy Solutions works with and cooperates with any state district attorney's office as well as individual judges, Today's Therapy Solutions employees will not render an opinion in custody or other kinds of civil cases for any party. A subpoena disrupts not only the schedule of the provider who is subpoenaed, but also all of those clients who had appointments set during the day of the subpoena. This requires a complete rescheduling of all clients on that date's calendar.

Please have your legal Counsel contact Today's Therapy Solutions' owners to arrange for witness testimony at least one week prior to the requested subpoena date and to pay the applicable full day rate for any TTS employee at least two days in advance of any subpoenaed court appearance. Further, if another party subpoenas a TTS employee in a case in which you are involved, because of custody or guardianship, and you utilize TTS services, you shall agree and guarantee that your legal counsel will recognize such subpoenaed TTs employee as a witness and move to protect the subpoenaed employee by filing a Motion to Quash such subpoena, informing all other parties and attorneys about TTS Court Appearance policy and taking any other steps necessary to protect the subpoenaed employee. You shall pay for all such legal services. In the event that TTS staff is required to appear in court, the daily rate below will apply.

The party who caused the subpoena to be issued is the responsible party for payment in full. Public entities, including court systems, are exempt from fee assessments. Payment must be made at least two business days prior to the appearance date, in the form of a certified check, cashier's check or money order.

Daily Fee for the Oklahoma City metro area: $700 per day which includes travel.

Fee outside the Oklahoma City area will include $.55 per mile for travel and any hotel expenses/meal expenses incurred for spending the night.

Please sign below to acknowledge you have received the above information and are compliant with the court appearance fee agreement should you so need it in the future.

_____	_____	_____	_____
Parent or Guardian Name	**Parent or Guardian Signature**	**Patient DOB**	**Today's Date**

Today's Therapy Solutions

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

*********ACKNOWLEDEGMENT OF NOTICE OF PRIVACY PRACTICES**:

The Notice of Privacy Practices tells you how we may use and share your health records. Please read it.

- We will use and share your health records to treat you and to bill you for the services we provide.
- We will use and share your health records to run our business.
- We will use and share your health records as required by law.

All the ways we may use and share your health records are explained in more detail in the Notice of Privacy Practices.

You have the following rights with respect to your health records:

1. You have the right to look at and receive a copy of your health records.
2. You have the right to receive a list of whom we have given your health records to.
3. You have the right to ask for us to correct a mistake in your health records.
4. You have the right to ask that we not use or share your health records.
5. You have the right to ask us to change the way we contact you.

All of these rights are explained in more detail in the Notice of Privacy Practices.

I acknowledge Today's Therapy Solutions Notice of Privacy Practices and understand I can obtain a copy via verbal request at any time.

Signature: _____ **Date**: _____
(Patient or Legal Representative)

Capacity of Legal Representative: _____

CONSENT:

I consent to the use and sharing of my health records for treatment, payment, and operation purposes as described in the Notice of Privacy Practices. I know that if I do not consent, you cannot provide services to me.
Oklahoma law requires that we advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus, and Acquired Immune Deficiency Syndrome (AIDS). It also may include mental health or other sensitive information.

Signature: _____ **Date**: _____
(Patient or Legal Representative)

Capacity of Legal Representative: _____

Dear Valued Client:

We strive to provide excellent care to you and the rest of our clients. As you are aware, we are a very busy practice dedicated to providing quality, consistent therapy services to children in the OKC Metro area. Assuring that all of our clients receive access to the therapy services they need is a constant challenge and requires guidelines. When you periodically cancel or reschedule with adequate advance notice, it most likely will not be a problem. However; if you cancel or no-show frequently it will not be possible to hold your spot for an extended period of time. Below you will see our cancellation policy.

- Please call the therapist or the office to cancel appointments as soon as possible.
- If you no-show you **will** need to contact the therapist to verify your next visit.
- More than 3 no-shows **will** result in termination of services.
- If you cancel more than 3 times in one month, you may be asked to discuss your situation with the therapist and services may be placed on hold.
- If you do not provide 24 hour notice of the cancellation or if you no show the appointment, the appointment may result in a charge of $25.00 to your account for the missed appointment

Our clinical office scheduled your appointment and reserved time for you in good faith. Please assist us in our goal of offering you timely appointments by adhering to this policy.
If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

ACKNOWLEDGEMENT OF CANCELLATION POLICY

I have received and read a copy of Today's Therapy Solutions Cancellation Policy. My signature indicates that I understand and will abide by the Cancellation Policy.

_____ _____

Signature of Patient or Legal Representation **Date**