Therapy Steps Inc.

P.O. Box 28528 Atlanta Georgia 30358 (404) 247 7959

CHILD'S NAME *(first middle last)*: _____ _

GAURDIAN #1 NAME: _____ RELATIONSHIP:_____
ADDRESS:_____
PHONE: _____ Type: ☐ cell ☐ work ☐ home
EMAIL: _____

GAURDIAN #2 NAME: _____ RELATIONSHIP:_____
PHONE: _____ Type: ☐ cell ☐ work ☐ home
ADDRESS:_____
EMAIL: _____

DATE OF BIRTH: _____

PEDIATRICIAN: _____
ADDRESS: _____
PHONE: _____
FAX: _____

ALL DIAGNOSES: _____
NEW DIAGNOSES IN 2025:_____
(date of diagnosis and doctor that gave diagnosis) _____
_____

Do you have a school IEP or BCW IFSP: ☐ YES ☐ NO
Are you enrolled in the BCW program: ☐ YES ☐ NO
CHILD SCHOOL /PRESCHOOL/DAYCARE NAME: _____
_____
DAYS/TIMES AT ABOVE LOCATION: _____

DOES YOUR CHILD HAVE ANY ADDITIONAL THERAPY NEEDS OR CONCERN YOU WOULD LIKE THERAPY STEPS TO ADDRESS:

_____
_____
_____

DOES YOUR CHILD GET ANY OTHER THERAPY OUTSIDE THERAPY STEPS? PLEASE LET THERAPIST NAME, LOCATION, EMAIL OR PHONE NUMBER

_____
_____

DO YOU GIVE US PERMISSION TO CONTACT ABOVE THERAPIST TO COORDINATE CARE WITH YOUR CHILD: ☐ YES. ☐ NO

PRIMARY INSURANCE INFORMATION:

Name of Insured:_____Relationship to Child:_____
Policy ID Number:_____ Group Number:_____
Insurance Company:_____
Phone Number:_____
Policy Holder's Date of Birth:_____

SECONDARY INSURANCE INFORMATION:

Name of Insured:_____Relationship to Child:_____
Policy ID Number:_____ Group Number:_____
Insurance Company:_____
Phone Number:_____
Policy Holder's Date of Birth:_____

TERTIARY INSURANCE INFORMATION:

Name of Insured:_____Relationship to Child:_____
Policy ID Number:_____ Group Number:_____
Insurance Company:_____
Phone Number:_____
Policy Holder's Date of Birth:_____

Therapy Steps Inc.
P.O. Box 28528 Atlanta Georgia 30358 (404) 247 7959

CONSENT FOR TREATMENT

I, knowing that _____child's name) has a diagnosis requiring physical, occupational, and/or speech therapy treatment, voluntarily consent to such care for the aforementioned child by Therapy Steps, Inc. as may be beneficial in the professional judgment of this child's therapist.

I am aware that the practice of physical, occupational, and speech therapy is not an exact science and I acknowledge that no guarantee has been made to me as to the effect of speech therapy treatment to my child.

Signed: _____
Parent/Guardian Relationship

Date: _____

RELEASE OF INFORMATION

I hereby authorize Therapy Steps, Inc. to release to all Insurance Companies only such therapeutic and financial information as may be necessary to determine benefits entitled to and process payment claims for therapy services that will be provided. I hereby authorize Therapy Steps, Inc to release physicians and the Babies Can't Wait Program therapeutic and financial information as may be necessary.

Signed: _____
Parent/Guardian Relationship

Date: _____

CONSENT FOR PAYMENT

I understand that my insurance will be billed the usual and customary rate for physical, occupational, &/or speech therapy. I understand that the Medicaid rate will be accepted if my child is covered by Medicaid or Babies Can't Wait Program.

I have read the above information regarding payment for therapy services by Therapy Steps, Inc. and fully understand this information. I authorize Susan E Nessmith, PT, owner, to bill my insurance company for direct reimbursement of therapy service rendered to my child. Benefit payment will be assigned directly to Therapy Step, Inc c/o Susan E Nessmith, PT.

Signed: _____
Parent/Guardian Relationship

Date: _____

Revised 10/01/2015

Therapy Steps Inc.
Post Office Box 28528 Atlanta, GA 30358
(404) 247 7959

Effective Date: April 14, 2003

Notice of Our Privacy Practices

In 1996, the Federal Government established uniform privacy and security standards to protect patients' medical information. The standard is known as the Health Insurance Portability and Accountability Act (HIPAA). The deadline for compliance is April 14, 2003.

The purpose of this notice is to ensure that you (the health-care recipient) or your designated representatives are aware of your rights to ensure the privacy of your healthcare information. Therapy Steps, Inc retains the right to update this notice at anytime. To obtain the most recent notice, please summit a request in writing to the Privacy Officer of Therapy Steps, Inc

1. Privacy of the Patient Information:
We have created a record of the services and treatment that you receive through Therapy Steps Inc. The privacy of your medical information is important to us and we are committed to protect it. We are required by law to keep your medical information private and notify you of your legal rights and privacy practices.

2. Uses and Disclosure of Patient Information:
Your medical information will be used for treatment, payment, and operations to maintain the highest quality of care possible. HIPPA allows disclosure of this information to your designated/authorized next of kin, licensed healthcare providers involved in your care, and other healthcare entities including insurance companies, state and federal regulation agencies, as well as law enforcement agencies in the interest of public safety. If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. Any other uses and disclosures of your personal health information will be made only with your written authorization. You may revoke such authorization in writing and we ate required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You, the patient, however, reserve the right in writing restrictions on certain uses and disclosures.

In addition to the above entities, Therapy Steps Inc may communicate with the following persons on my behalf for treatment and my health conditions: for example: Treating Physicians, Therapists, Billing Service Provider, School System.

_____
_____
_____
_____

3. Your rights regarding Medical Information About You:
You have the right to inspect and copy your personal health information kept on file with Therapy Steps Inc. You have the right to amend information we have about you that is incorrect or incomplete. You have a right to request restrictions on the medical information we use or disclose about you for treatment and payment. You have a right to an accounting of disclosures we made of medical information about you. All of the above request may be submitted in writing to the Privacy Officer of Therapy Steps Inc at the address listed above.

4. Patient's (or Designee's) Personal Communication:

You may communicate confidential information, including services, to me by the following means:

U.S. Mailing Address: _____

Telephone Number (s): _____

E-Mail: _____

Patient's Name: _____ Date of Birth:_____

Parent/ Legal Guardian: _____
(Please Print Clearly)

Parent / Guardian Signature:_____

Date: _____ Relationship to Patient: _____

5. Patient's Access to Medical Information

You have the right to see and obtain a copy of your medical records at any time. You may request changes to your health information and request the reason for any disclosure (not including treatment, payment, and healthcare procedures).
If Therapy Steps, Inc. does not agree with your changes, you must be allowed to insert a statement of disagreement into the record. Therapy Steps, Inc. is not required to agree to your requested restrictions. However, if we agree, the restriction is binding.

6. Confidentiality of Patient Information

Therapy Steps, Inc. will attempt in all cases to preserve the confidentiality of all oral and written medical information. This includes progress information at the end of treatment sessions, written information and electronic transmission of information to physicians, insurance companies, state and federal entities, and law enforcement agencies in the interest of the public safety. Therapy Steps, Inc. will not be held responsible in the event of natural disaster, theft, or burglary of their physical or electronic property, having taken reasonable precautions.

7. How to File a Complaint

You may file a complaint if you feel that your privacy rights have been violated. Therapy Steps, Inc. will not retaliate against you if you file a complaint. You may file a formal, written complaint with us at the address below, or with Department of Health & Human Services, Office of Civil Rights, in the Event you feel your privacy rights have been violated.

8. Therapy Steps, Inc. Contract Information

You may contact Susan Nessmith, the Privacy Officer of Therapy Steps, Inc., for more information on our privacy policy at the below address and telephone number

Therapy Steps Inc.
Post Office Box 28528 Atlanta, GA 30358
(404) 247 7959

Please note this is a summary regarding our privacy policies. If you would like a detail policy, please contact Therapy Steps, Inc. in writing or by telephone.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(877) 696-6775 (toll-free)

Therapy Steps Inc.

CREDIT CARD ON FILE AGREEMENT

Therapy Steps requires a credit card to be on file for payments due to Therapy Steps Inc for services rendered. By providing us with your credit card information you are giving Therapy Steps permission to automatically charge your credit card for payment due after your insurance has processed your child's therapy claim. Please note there is a 5% fee for any declined charges and 15% fee for charges that are over 30 days past due. The billed amounts will match the patient responsibility amount as determined by your insurance or BCW. There are no co-pays or fees for services if you have Medicaid, CMO, or Deeming Waiver Medicaid as primary or secondary insurance. If Therapy Steps is on your IFSP as an authorized provider, you will only be charged your family cost participation as indicated by the BCW financial policy.

Any missed appointment without cancellation will result In the credit card on file being charged a no show fee of $50.00 per hour. Any cancellation less than 24 hours of appointment time will result in the credit card on file being charged a fee of $25.00 per hour. If Therapy Steps is able to fill your canceled appointment, we will waive your later fee charge.

If the credit card information we have on file changes for any reason, you must notify Therapy Steps at therapystepsbilling@gmail.com as soon as possible. If you have any questions about a charge, please notify us within 15 days. After 30 days all charges will be assumed to be correct.

We will maintain a clear record of all payments and charges. However in the result that an overpayment occurs your account will be credited on the upcoming invoice or if the balance is zero a reimbursement can be put back on the same credit card or a check can be mailed directly to you. A receipt will be sent to you from our credit card processing company.

In the event of a declined charge you will be asked for a new credit card number and or payment before continuing therapy services.

I HAVE READ AND UNDERSTAND THE CREDIT CARD ON FILE AGREEMENT AND AUTHORIZE THERAPY STEPS TO CHARGE MY CREDIT CARD AS ABOVE STATED ABOVE

Please Check one of the following: ☐ **VISA** ☐ **MasterCard** ☐ **American Express**

Credit Card Number: _____

Exp. Date: _____/_____

Security Code: _____

Billing Zip Code: _____

Child's Name: _____

Name on Credit Card: _____

Billing Address*: _____

_____ ***Initial here*** ***I understand all charges will be charged to this card on file. Paid invoice will sent to me at the time of charges to the email below.***

Signature: _____ Date: _____

Email for for billing invoice: _____

P.O. Box 28528 Atlanta Georgia 30358 (404) 247 7959

ATTENDANCE POLICY

At Therapy Steps Inc, our greatest desire is to deliver the highest level of care to our patients. To maximize the benefits of therapy, consistent attendance is critical. Patient commitment to attend therapy as scheduled leads to better potential for patient progress. Missed and tardy appointments disrupt the therapist's schedule, slow your child's progress, and prevents other children from having the opportunity to receive services. *Furthermore, failure to regularly attend scheduled therapy sessions may result in insurance denying coverage of your child's therapy services*.

By initialing each item listed and signing below, you are indicating that you understand the attendance policy and the consequences of not keeping your child's appointments. We anticipate that you will adhere to the following:

_____ 1. I understand Therapy Steps has an attendance policy of $\geq$75% attendance to maintain a set ongoing weekly appointment time. If my child's attendance drops below this, I will need to schedule week to week and understand my day and time may vary. If my child 's therapist cancels this will not be marked as a cancellation and your attendance will be marked present.

_____ 2. If I need to cancel an appointment, I agree to call or text at least 24 hours in advance. I understand that if I call after business hours, I may leave a voicemail or text with my child's name, therapy to be cancelled and reason for cancellation. I **understand my credit card will be charged $25 for a late cancellation**.

_____ 3. I understand that missing an appointment without calling ahead is considered a "no show". I understand that calling within an hour of the appointment is still considered a "no show**". I understand that after 2 "no shows", my child will be removed from the schedule. I understand my credit card will be charged $50.00 for a no show.**

_____ 4. I understand that if I arrive fifteen or more minutes late, I may not be seen that day and it will be considered a "no show". Additionally, we kindly request that you plan to return to the waiting room at our clinic or your child's home session at least 10 minutes prior to the scheduled end time of your child's session.

_____ 5. To avoid a "no show", I will refrain from scheduling other appointments around my scheduled therapy time.

_____ 6. I understand that my referring physician will be notified if I am removed from the schedule due to inconsistent attendance.

_____ 7. I understand that if my child is seen for 2 or more therapies on the same day and one therapist must cancel, I am still responsible for bringing my child to his/her other therapies.

_____ 8. I understand that Therapy Steps does not "hold" appointment spots. If your child needs to be placed on hold due to insurance, prolonged vacation, medical procedures, you will need to reschedule upon your return.

CHILD'S NAME _____. DOB_____

PARENT / LEGAL GAURDUAN NAME _____ Relation: _____

_____ _____

Signature Date

Media Consent/Release Form

I hereby authorize Therapy Steps Inc. to use my child's image and following information (check all that apply):

- ☐ First name
- ☐ Diagnosis
- ☐ Age
- ☐ Length of time receiving services
- ☐ Therapy Disciplines received (ex. OT, PT, ST)

I authorize use of this information in the following platforms (initial all that apply):

_____ (*Initial*) Within the clinic for celebrations (milestones, etc)

_____ (*Initial*) Digital or print publications, including, but not limited to, Newsletter, audiovisual presentations, social media, and/or Therapy Steps website (ex. Facebook, Instagram)

_____ (*Initial*) Promotional, educational, and/or marketing material

_____(Initial) Video and Picture to be shared with *you as the parent only* for Home Exercise Program. These videos and pictures will not be shared with any other parent or online/social media. You also authorize us to send these videos and pictures to your phone number on file.

My consent is freely given as a public service to Therapy Steps Inc., without expecting payment. I release Therapy Steps Inc., from any and all liability which may arise from the use of such news media stories, promotional materials, written articles, video and/or photographs.

I understand that I can revoke this release at any time in writing and that the use of any photos or other information authorized by this release will immediately cease.

I have carefully read and understand the provisions of this media release form.

Patient Name: _____ Date:_____

Caregiver/Parent Printed Name: _____

Caregiver/Parent Signature:_____

5885 Glenridge Drive Suite 110, Atlanta GA 30328
P : (404) 247-7959 F : (404) 393-2447 E therapystepsinc@gmail.com