PATA REHABILITATION SPECIALISTS

Date: _____

Dear _____,

This packet contains forms to be completed and returned by e-mail or mail prior to your appointment. **Once you have returned these forms, you will be contacted to schedule your initial evaluation.** If you e-mail the forms, please bring the originals on the date of the appointment. If you have additional information (e.g., a recent report from your ENT, results of school speech and language testing), please submit those as well. Should you have questions about the completion of these forms, please contact us at 570-406-9083.

Please return forms to:

PATA Rehabilitation Specialists
100 N. Wilkes Barre Blvd., Suite 201
Wilkes Barre, PA 18702

Sincerely,

The PATA Rehabilitation Specialists Team

Please make sure to complete the following items:

- ☐ Complete this packet
- ☐ E-mail or mail this completed packet (If the packet is e-mailed, please bring original forms to your evaluation)
- ☐ Send other relevant reports

PATA REHABILITATION SPECIALISTS

General Consent Form

Patient Name: _____

_____ **Consent for Assessment/Reassessment and Treatment**
(Initial here)

I understand that PATA Rehabilitation Specialists, acting through its personnel, may desire to administer such assessment/treatment, it deems necessary or appropriate in its efforts to assist my family member/me. I therefore give consent and authorize PATA Rehabilitation Specialists and its staff to perform such assessment and treatment procedures as may be necessary or appropriate in the care and treatment of myself or my family member until such consent is revoked in writing.

I acknowledge that I or my family member has been voluntarily presented for treatment; that a satisfactory disclosure of information has been made and that all of my questions asked about the procedure(s) have been answered in a satisfactory manner by the speech-language pathologists. Should care be discontinued at my request, contrary to the advice of the speech-language pathologist, I relieve PATA Rehabilitation Specialists of all responsibilities for any untoward results which may follow.

I understand that PATA Rehabilitation Specialists offers no guarantees about a cure of my/my child's/my family member's condition or any other results or benefits of the recommended therapy. I understand that I have the right to refuse the recommended course of treatment, as well as the right to withdraw from treatment at any time.

_____ **Consent for Videotaping, Audiotaping, and Observations**
(Initial here)

I understand that I or my family member may be observed for education or research purposes while receiving services at PATA Rehabilitation Specialists. It is understood that the staff, observers, and students will consider any information revealed during such examinations or demonstrations as privileged communications and will hold such information in confidence.

_____ **Notice of Privacy Practices**
(Initial here)

I have received and understand this practice's Notice of Privacy Practice written in plain language. This notice explains in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and the practice's legal duties with respect to my protected health information.

Signature of Client or Parent/Legal Guardian (relationship) Date

PATA REHABILITATION SPECIALISTS

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for PATA Rehabilitation Specialists. A copy of this signed, dated document shall be as effective as the original.

_____

Print name of Patient Patient Signature

_____

Parent/Guardian Name Relationship of Guardian

How would you like to be addressed when summoned from the reception area?

☐ First name only ☐ Proper surname ☐ Other _____

Please list any other parties who can have access to your health information:
(This includes stepparents, grandparents, and any caretakers who can have access to this patient's records):

Name: _____ Name: _____

Relationship: _____ Relationship: _____

I authorize contact from this office to **confirm my appointments, treatment, and billing information**, as well as **information about my health** to be conveyed via:

Home phone: _____ Leave a message? ☐ Yes ☐ No

Work phone: _____ Leave a message? ☐ Yes ☐ No

Cell phone: _____ Leave a message? ☐ Yes ☐ No

Text Message to my Cell Phone: ☐ Yes ☐ No

E-mail: _____ ☐ Yes ☐ No

_____ _____

Patient or Parent/Legal Guardian Signature **Date**

**A parent must provide a court order of sole custody or other legal documentation when requesting medical information be withheld from another parent. We cannot purposely withhold information when requested by a parent without a court order or legal documentation.*

PATA REHABILITATION SPECIALISTS

Fee Schedule and Payment Policy as of March 1, 2017

The following is the current Fee Schedule and Payment Policy for services to be provided to you by PATA Rehabilitation Specialists. Please understand that this facility reserves the right to change and/or modify the fees set forth below, but you will receive 30 days advanced notice of any increase in such fees. All fees and costs shall be due and payable in accordance with the Agreement to Terms of Payment.

Evaluation	TBD by length/content of evaluation	Individual; Includes written report
Treatment (1-hour)	$75.00	Individual
Treatment (30 minutes)	$40.00	Individual

Payment for Services

For your convenience, we participate with many insurance plans and offer affordable private pay options. We accept the following forms of payment: cash, check, Visa, MasterCard, and Discover.

Cancellation and No-Show Policy

Appointments that are not cancelled are considered “no-shows”. If you no-show for a scheduled appointment, you will incur a $55.00 no-show fee. Cancellations less than 24 hours before your scheduled appointment will incur a $25.00 short-notice cancellation fee. For all cancellations, please call 570-406-9083 or e-mail patarehab@gopata.org. We greatly appreciate as much advanced notice as possible of vacations or other events for which you are unable to keep your appointment.

PATA REHABILITATION SPECIALISTS

Agreement to Terms of Payment

I, _____, acknowledge and accept full and complete responsibility for payment of all services rendered to me/my child/any individual under my care by PATA Rehabilitation Specialists or its consultants. I acknowledge that I have received written explanation of the fee schedule, cancellation policy, and payment policy and I agree to all policies. I understand that health insurance policies are an arrangement between my insurance company and myself, that all services rendered to me/my child/any individual under my care are charged directly to me, and that I am personally responsible for payment. I understand that agreements regarding fee schedules, charges for cancelled appointments and late payment fees are between myself and PATA Rehabilitation Specialists and are not related to potential insurance coverage. I understand that PATA Rehabilitation Specialists may assist me in completing forms to aid in collecting insurance benefits for services that are billable, but ultimately it is my responsibility to complete and file such forms. I agree to the release by PATA Rehabilitation Specialists and/or its duly authorized agents of any information that is requested by my insurance company.

_____ _____

Signature of Patient/Legal Guardian Date

_____

Print Name

PATA REHABILITATION SPECIALISTS

Patient Name _____ Date _____

Home Phone ( ) _____ Cell Phone ( ) _____

If Child (Parent or Guardian Name) _____

Address _____ State _____ Zip _____

Birth Date _____ Sex ☐M ☐F Social Security # _____

Referred By _____ Family Dr _____ Last Visit _____

Emergency Contact & Telephone _____

Employer & Telephone (If under 18, please list Employer of Parent) _____

Allergies _____ Marital Status _____

Pharmacy _____ Telephone _____

PRIMARY HEALTH INSURANCE

INS Name _____

Address _____

_____

ID # _____

Group # _____

SECOND HEALTH INSURANCE

INS Name _____

Address _____

_____

ID # _____

Group # _____

Subscriber's Name _____ Relationship _____ DOB _____

Telephone ( ) _____ Cell Phone ( ) _____

****

I, the undersigned, hereby grant permission to release my medical information and authorize payment of benefits to: PATA Rehabilitation Specialists, I also understand that I am fully responsible for payment of DEDUCTIBLES AND CO-PAYMENT and any charges that are incurred and not covered by my insurance. MEDICARE PATIENTS: "I request that payment of authorized Medicare benefits be made either to me, or on my behalf to: **PATA Rehabilitation Services,** for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits and payment for related services".

SHOULD THIS ACCOUNT GO TO COLLECTIONS FOR NON-PAYMENT, THE PATIENT/GUARANTOR ACCEPTS RESPONSIBILITY FOR ALL COLLECTION FEES, INTERESTS AND COSTS.

Signature_____ Date_____

PATA REHABILITATION SPECIALISTS

Credit Card/Debit Transaction Processing Authorization Form

☐ Yes, I would like PATA Rehabilitation Specialists to automatically charge my credit card following each instance of services rendered.

☐ Yes, I would like to have my checking account debited for services following each instance of services rendered.

☐ No, I do not authorize PATA Rehabilitation Specialists to charge my credit card/debit my checking account for services rendered.

Card Type: ☐ Visa ☐ MasterCard ☐ Discover

Name on card: _____

Billing Address: _____

_____

Card Number: _____

Expiration Date: ____/_____ CVC Code: _____

By signing this Agreement, and marking the box noted above, the undersigned does hereby agree as follows: (i) the undersigned does hereby authorize and agree that PATA Rehabilitation Specialists has the right from time to time to charge to the above identified credit card and/or debit the account identified above any and all amounts that are owed to this facility and/or its consultants, (ii) the undersigned agrees that its signature on this Agreement shall be deemed its signature on any sales charge receipt or other form and if any merchant services, credit card company, or bank requests to view the undersigned signature on a sales charge receipt or other form, this facility may provide such company with a copy of this Agreement and such shall be deemed conclusive proof that the undersigned approved and authorized the charge and/or debit at issue, and the undersigned does hereby waive any right to dispute its authorization to such charge based on an invalid or non-existent signature. The undersigned understands and agrees that the above payment option and charges or debits will continue each time services are rendered by PATA Rehabilitation Specialists and/or its consultants until such time as the undersigned has provided written notice to this facility to stop such automatic charges and/or debits. The undersigned shall be fully responsible for ensuring that it has sufficient credit and/or funds to cover the charges or debits, and shall indemnify PATA Rehabilitation Specialists against all costs incurred as a result of any declined charge or debit.

Cardholder's Signature: _____ Date: _____

Print Name: _____

I, _____, authorize PATA Rehabilitation Specialists to send paid invoices via e-mail in PDF format to _____.

(your email address)

Signature: _____ Date: _____

PATA REHABILITATION SPECIALISTS

Hold Harmless Agreement

I, _____, acknowledge and agree to receive speech, language, and/or voice services from PATA Rehabilitation Specialists and/or any independent contractor under the foregoing at PATA Rehabilitation Specialists. I acknowledge that there is some risk inherent in the use of therapy equipment and I agree to assume such risk and indemnify and hold PATA Rehabilitation Specialists harmless from any and all losses and claims for any injuries or other damages occurring to myself, my child, or our belongings.

_____ _____

Signature of Patient/Legal Guardian Date

_____

Print Name