Therapy Hut, Inc.

895 Willow Tree Circle, Ste.100, Cordova, TN 38018

Phone Number: 901-309-5219 // Fax Number: 901-309-5265

Info@therapyhut.com

Please complete form, please print

Initial Intake Form

PLEASE NOTE: A payment of $250.00 must be made before all initial evaluations for Occupational Therapy, Physical Therapy and Speech and Language Therapy. Some exclusion may apply. The break down of the 250.00 is 150.00 goes to evaluation charge and 100.00 non-refundable fee goes to consultation, meeting with parent, planning and documentation.

Please initial: _____

Services you are requesting: **Speech Therapy: ___ Occupational Therapy: __ Physical Therapy: ___**

Person completing this form: _____
Relationship to Patient: _____
Patient's Full Name: _____
Nickname: _____Sex: ___Male ___ Female Date of Birth _____
School Patient Attends: _____
Social Security #:_____ Patient's Medical Diagnosis: __
_____
Home Address: _____
City: _____ State: _____ Zip Code_____
Home Phone: _____Mom's Name/Work Number: _____
Mom's Cell Number: _____ Dad's Cell Number: _____
Dad's Name/Work Number: _____
Parent's E-Mail Address: _____

Emergency Contacts:

Name/Relationship: _____ Contact Number: _____
Name/Relationship: _____ Contact Number: _____
Name/Relationship: _____ Contact Number: _____

Doctor's Name: _____
Office Address: _____
Doctor's Phone and Fax Number: _____
Doctor's Nurse's Name: _____

Referred By: _____

Doctor's Orders:

I understand that some therapy services require a written physician's order for evaluation and ongoing treatment. I also understand that it is my responsibility to request the physician's orders and have them forwarded to Therapy Hut prior to the onset of services. **Sessions can not be scheduled unless orders are received.**

Initial: _____ Date: _____

Therapy Hut, Inc.

895 Willow Tree Circle, Ste.100, Cordova, TN 38018

Phone Number: 901-309-5219 // Fax Number: 901-309-5265

Info@therapyhut.com

Please complete form, please print

Person Responsible for Account: (First/Middle/Last) _____
Relation to Patient: _____ Date of Birth: _____Social Security #:_____
Address and Phone # (if different from Patient's):___ _____
Person Responsible Employed by: _____Occupation: _____
Business Address: _____ Business Phone: _____

Insurance Information

Primary Insurance Information: *

Name of Insurance: _____ Effective Date: _____
Subscriber Name: _____ Relationship to Patient: _____
Address and Phone # (if different from Patient's) ___ _____
_____
Insured Date of Birth: _____Social Security #:_____
Insurance Company Address: _____
Insurance Phone #:_____ Group #: _____
Subscriber / ID #:_____

****Secondary Insurance Information: ****

Name of Insurance: _____ Effective Date: _____
Subscriber Name: _____ Relationship to Patient: _____
Address and Phone # (if different from Patient's) _____ _____
_____
Insured Date of Birth: _____Social Security #:_____
Insurance Company Address: _____
Insurance Company Phone #:_____ Group #: _____
Subscriber / ID #_____

****Third Insurance Information: ****

Name of Insurance: _____ Effective Date: _____
Subscriber Name_____ Relationship to Patient: _____
Address and Phone # (if different from Patient's) _____ _____
_____
Insured Date of Birth: _____Social Security #:_____
Insurance Company Address: _____
Insurance Company Phone #:_____
Group #: _____Subscriber / ID #:_____

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Therapy Hut, Inc. call insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature for all insurance submissions.

Therapy Hut, Inc.

895 Willow Tree Circle, Ste.100, Cordova, TN 38018

Phone Number: 901-309-5219 // Fax Number: 901-309-5265

Info@therapyhut.com

Please complete form, please print

Signature: _____ Date: _____

Therapy Hut, Inc. Release and Consent Form:

Patient Name: _____ Date of Birth: _____

Please check all the lines that are applicable.

Consent to Evaluate and Treat:

I do hereby consent to the following:

Yes____ No ____ 1. Evaluation by the Therapy Hut staff

And/or

Yes____ No ____ 2. Treatment services as recommended by the Therapy Hut staff

Medical Emergencies:

Yes____ No ____ In the event that a medical emergency should occur while the patient is being treated by Therapy Hut staff and parent/legal guardian/emergency contact cannot be reached, emergency medical care will be sought at the nearest medical facility.

Release of Information:

Yes____ No ____ I authorize Therapy Hut to release diagnostic reports and clinical reports to the patient's physician, legal guardian, other service providers, school system (Circle those that apply).

Please provide names, addresses, and phone numbers to all agencies you wish to provide information:

_____

_____

Yes ____ No ____ I authorize physician, legal guardian, other service providers, school system (circle those that apply) to release medical, diagnostic clinical, psychological/ an/or educational records to Therapy Hut and for Therapy Hut to release medical, diagnostic clinical, psychological to them when appropriate. This release covers any verbal and/or written communication.

Please provide names, addresses, and phone numbers to all agencies from which you wish us to obtain information:

_____

_____

Media Release: *Yes_____* *No_____*

I give permission for video and audio taping and photography of my child for educational, research, marketing and use in the training of therapy students and professionals. This release shall remain effective permanently unless otherwise specified in this document.

Therapy Hut, Inc.

895 Willow Tree Circle, Ste.100, Cordova, TN 38018

Phone Number: 901-309-5219 // Fax Number: 901-309-5265

Info@therapyhut.com

Please complete form, please print

_____ _____

Signature of Client/Parent or Legal Guardian Date

Patient Financial Policy for Therapy Hut, Inc.

Patient's Name: ________ Date of Birth: _____

Patient / insured agrees to pay for all portions of services due in full at the time services are provided by our office.

Patient Financial Class Policies:

You are required to present a valid insurance card at the initial visit, when your insurance policy changes, when you change insurance carriers and as needed throughout your care.

Commercial Insurance Carriers: We bill most insurance carriers for you if proper paperwork is provided to us. Any outstanding balances, co-payments and deductibles are due prior to checking in for you appointments. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less that anticipated for care. **If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you.**

TennCare: Some of our therapists are TennCare Select participating providers and we will bill TennCare Select for you. Any outstanding balances, co-payments and deductibles are due prior to your appointments.

Wellness Programs / Self-Pay: _____ At Time of Service

Methods of Payment:

Our office accepts the following payment methods: Cash, Personal Check, Credit Cards and Patient Financing options for those patients who are credit worthy.

- **For returned checks we assess a $45.00 NSF charge, and report to the local district attorney's office checks that are not paid within 2 weeks of being returned to our office. Initial: _____**
- **There is a $ 75.00 charge for no shows and/ or if the appointment is not cancelled within 4 hours. Initial: _____**
- If not paid according to terms the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections patient agrees to pay all additional fees accessed in the collection of the debt. These fees include collection agency fees and attorney fees. **Initial: _____**

All Co-pays, Deductibles and Coinsurance are due at time of service...

The patient is ultimately responsible for all fees for services. I have read, understood and agreed to the above financial policy for payments of professional fees.

Therapy Hut, Inc.

895 Willow Tree Circle, Ste.100, Cordova, TN 38018

Phone Number: 901-309-5219 // Fax Number: 901-309-5265

Info@therapyhut.com

Please complete form, please print

Signature: _____ Date: _____