ADVENT THERAPY
Physical•Occupational•Speech Therapy

10144 Ford Avenue, Richmond Hill, GA 31324
912.727.2321 Fax: 912.445.0599
www.AdventTherapyRH.com

Patient name: _____

Preferred contact phone: _____

Emergency contact phone: _____

Name and relationship of emergency contact: _____

Patient e-mail address: _____

Name of provider: _____

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.

_____ CONSENT TO CONTACT
I agree to receive communication related to my appointment or that of my dependents via text message, email, and/or phone from the office representatives at the specific points of contact I have provided. Messages related to my appointment or that of my dependents may be left on my answering machine, voice mail, or sent via text.

_____ 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 furnished to me by that provider. I authorize 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.

_____

Parent/Guardian/Patient Signature Date

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Patient Responsibility and Insurance Disclaimer

Insurance Disclaimer:

A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service.

Insurance Liability for Payment:

Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures pre authorized by your health insurance company, when applicable. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service. We suggest to all patients that they contact their insurance to confirm that these services are covered prior to scheduled appointments.

Under this arrangement, you are responsible for paying your co-pay at time of service, any non-covered portions, and any deductible you have yet to cover will be billed in a timely manner. In addition, if your insurance company does not pay for our services, you agree to pay for the services provided in our clinic.

Beneficiary-Agreement:

I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does not make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

_____

Parent/Guardian/Patient Signature Date

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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 their 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 Show:**

A No Show appointment is any missed appointment with failure to provide 24 hour notice to the front office by phone or voicemail. After three No Show appointments, (not rescheduled or made up within the week of missed appointment), the patient may be removed from the recurring schedule. This excludes any illness or emergency situations. Two or more No Show appointments constitutes a missed appointment fee as listed below, the first No Show appointment does not incur a fee.

_____ **Cancellation:**

A Cancellation is any appointment canceled with a notice greater than 24 hours by phone or voicemail to the front office. Any appointment that is rescheduled within the same week does not incur a penalty. If your attendance falls below 75% there is no longer a guarantee to hold a recurring appointment time.

All contact to the clinic regarding attendance should be made directly to the front office. Any forms of notice directly to a therapist by email or phone will not be accepted as valid notice.

_____**Missed Appointment Fees:**

Missed appointments without a 24 hour notice to the front office will incur a fee of **$30 per 30 minute appointment** and **$60 per one hour appointment**. If multiple therapies are missed in one day, the maximum charge is $100 per patient, per day.

All missed appointment fees incurred will be due at next the next scheduled appointment.

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Acknowledgment and Receipt of Privacy Policies

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

_____

Patient Name

_____

Parent/Guardian/Patient 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 low grade fevers.)
Highly contagious conditions, including but not limited to: Flu, Stomach Virus, Diarrhea, Hand Foot and Mouth, Conjunctivitis (Pink Eye), Head Lice, or Ring Worm.
Severe Respiratory Problems (labored breathing, thick or odd-colored nasal discharge, severe coughing)

_____

Parent/Guardian/Patient Signature Date