Raise The Bar Therapy Services
Pediatrics
16525 US Highway 17 N, Suite D, Hampstead, NC 28443
v. 910-803-4085 | f. 910- 910.939.1519| www.dogwoodtherapy.net/raisethebartherapy.com

Patient Information Form **Date: ________________**

Child's Full Name:______________________________DOB:___________Age:_________Sex: M/F Child's Address:________________________________City:_____________State:_______Zip:________Child's School/Daycare:____________________________________Phone: _______________________

Guardian Name (1)______________________________Street Address: ____________________________
City:______________________State:_________Zip:___________Email:______________________________
Home Phone:__________________Work Phone:__________________Cell Phone: ___________________
Preferred Method of Contact (please circle): Home Work Cell Email

Guardian Name (2)______________________________Street Address: ____________________________
City:______________________State:_________Zip:___________Email:_______________ Home Phone:___
_________________________Work Phone:________________Cell Phone: ________________________
Preferred Method of Contact (please circle): Home Work Cell Email

Emergency Contact:________________________Relationship:_______________Phone:_____________

Referring Physician/Pediatrician (Name/Facility): ____
Physician Phone:_____________________________Physician Fax: ________________________________

Results will be sent to names/locations listed below if address or faxes are provided

Name Address or Fax Phone

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Disclosure of healthcare information will only be provided if authorized by the caregiver.

Primary Insurance:
Policy Holder's Name:_______________________________DOB:__________Relationship:_____________
SSN:_______________________Policy #:_______________________Group #: ___________________
Insurance Company:_________________________________Employer:____________________________
Insurance Company Address:______________________________________Phone: __________________

Secondary Insurance:
Policy Holder's Name:_______________________________DOB:__________Relationship:_____________
SSN:_______________________Policy #:_______________________Group #: ___________________
Insurance Company:_________________________________Employer:____________________________
Insurance Company Address:______________________________________Phone: __________________

Release of Information Form

Date: ________________

Child's Name:____DOB:_______________________
Guardian/s:____
Address:____________________________________City:________________________________
State:_________________Zip Code:____________Phone Number: __________________________

- I hereby authorize any physician, clinic, hospital, institution or school to release medical and psychological information regarding my child, (Child's Name)__________________________to Raise The Bar Therapy Services. I understand that this information is to be used for professional purposes only and that it will be regarded as confidential. I also authorize Raise The Bar Therapy Services to contact any persons or institutions to obtain any additional information regarding my child, when necessary.

  Signed________________________________
  (Guardian)
- I hereby authorize Raise The Bar Therapy Services to release therapy reports regarding my child, (Child's Name)___________________________________, to any entity or professional associated with my child's care (physicians, any clinic, hospital, institution, insurance company, school, and other), with the exception of_________________________________.

  Signed________________________________
  (Guardian)
- I,______________________________, give my permission for Raise The Bar Therapy Services. to photograph and/or videotape my child (Child's Name),______________________________, and use said photos/videos for promotional or teaching purposes.

  Signed________________________________
  (Guardian)

Consent for Treatment

1. I authorize a therapist with Raise The Bar Therapy Services to perform the Speech-Language Therapy with (Child's Name) ____________________________. **Initials** _______
2. During any treatment session, unforeseen conditions may occur which may necessitate additional or different treatments. I, therefore, authorize a Raise The Bar Therapy Services employee or designee, to perform necessary treatments to remedy any unforeseen conditions which may occur. **Initials** _______
3. I authorize a healthcare/therapy student to be present in the room during the therapy session for observation purposes: **YES / NO**
4. I authorize Raise The Bar Therapy Services to leave voicemail message on the following phone number __________________________and relevant messages with the following individual(s) ____. **Initials** _______
5. I authorize Raise The Bar Therapy Services to text appointment changes or reminders to the following number _______________________________or email____________________________________**Initials** _______
6. I understand it is my responsibility to contact my insurance to understand my copay, deductible and limits of my benefits. I am aware I will be held responsible for costs that exceed my plan. **Initials** _______
7. I understand it is my responsibility to inform the office immediately of any changes to address, insurance coverage, general physician/pediatrician. Failure to do so could lead to claim denials to for insurance billing. **Initials** _______
8. I hereby assign the medical benefits to which I am entitled from private insurance and other health plans to Raise The Bar Therapy Services. to release information necessary to secure payment. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize Raise The Bar Therapy Services to receive direct payment for therapy services rendered to my child. **Initials** ________

________________________________ ________________________________

Guardian Signature | Relationship to Patient | Date

Appointments and Cancellation Policy for Medical Appointments

Thank you for choosing Raise The Bar Therapy Services as your therapy provider. The staff and therapists strive to make your experience here positive and to provide quality care for your child. In order to do so, we take your attendance at scheduled therapy visits very seriously. In order for your child to achieve maximum therapeutic benefits, they must regularly attend their appointments. By coming to your visits and adhering to recommended home exercises, your child can make great progress.

For Scheduled Appointments:

To schedule an appointment, please call or text our office at 910-803-4085. At the time of your arrival, please sign in at the front desk. A parent or guardian must be in the waiting room 5 minutes prior to the end of their child's appointment.

Cancellation of an Appointment:

In order to be respectful of the therapy needs of all of our Raise The Bar Therapy Services patients and their families, please be courteous and inform our office promptly if you are unable to attend an appointment. If it is necessary to cancel your scheduled appointment, we require that you call a minimum four hours in advance of your scheduled time. You may call our office at 910-803-4085 and advise your clinician of the cancellation or you may leave a detailed message if we were unable to answer your call. Alternatively, you may cancel via email at this time, info@dogwoodtherapy.net.

No Show Policy:

A "no show" is someone who misses an appointment without canceling within four hours of their scheduled appointment or who fails to arrive within 15 minutes of their appointment. "No Shows" cause other children to not be seen in a timely manner and disrupts their therapist's schedule. Most importantly, they cause disruption in your own child's progress toward meeting his or her goals. There will be a $30 charge for each "no show". Three "no shows" will result in the child being discharged from Raise The Bar Therapy Services and taken off the current schedule. If the discharged child's family wishers to resume therapy, they will have to contact our office and be placed on the waiting list. Of course, we know that there will be special cases, and will evaluate those as needed on an individual basis.

Late Cancellations:

Cancellations made less than four hours before a scheduled appointment will be considered as a "no show". In addition, if you are more than 15 minutes late for your appointment time, this will also be considered a "no show". We encourage and recommend you discuss with your therapist and our front office personnel your appointment needs, insurance benefits and any financial concerns you may have. We will not judge or discriminate in anyway, but greatly appreciate the opportunity to help in your situation and its' role in your child's therapy process. From these discussions, your therapist is able to plan your child's individualized program. We ask you to schedule appointments only if you are certain you will be able to attend and commit to those times. Thank you, again for choosing Raise The Bar Therapy Services as your provider. We look forward to serving you and your child.

I,______________________________, have read and understand the above Appointment and Cancellation Policy.

Signature:____Date: _________________________

Employee Signature:____________________________________Date:__________________________