SHARKKS
Therapy

PATIENT INFORMATION

Last Name:	First Name:	Middle:			
Best Phone Number	Cell Phone Number:	Home Phone Number:	Birth date:	Age:	Sex:
☐Cell ☐Home	( )	( )	/ /		☐M☐F
Street address:					
City:	State:	ZIP Code:			
Email Address:			S.S.#		

PHYSICIAN INFORMATION

Name:	Address:	Phone:

INSURANCE INFORMATION

{PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Insurance company Name:		
Employer:		
I.D. Number:	Address:	Phone:
Policyholder:	Group Number:	
Insurance Company Address:	Relationship:	

SECONDARY INSURANCE INFORMATION

{PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Insurance Company Name:	
Employer:	
Policyholder:	Group Number:
Insurance Company Address:	Relationship:

I certify that SHARKKS Therapy has made available to me a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bill or in the performance of SHARKKS Therapy's health care operations. The Notice of Privacy Practices also describes my rights and SHARKKS Therapy's duties with respect to my protected health information.

SHARKKS Therapy reserves the right to change the privacy practices that are described In the Notice of Privacy Practices. I may obtain **a revised** Notice of Privacy Practices by calling the office and requesting a revised copy be sent In the mail or asking for one at the time of my next appointment

I understand and agree to pay a **$35.00** fee for any No-Show appointment or for any appointment canceled with less that 24 hour notice.

I understand and acknowledge that I am financially responsible for all charges, whether or not paid by insurance. I also acknowledge direct assignment of my rights and benefits under my insurance policy to SHARKKS Therapy, LLC.

I hereby authorize payment directly to SHARKKS Therapy, LLC of all Insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by insurance for services rendered on my behalf or my dependents. I authorize the above providers to release any Information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Gaurdian Signature: _____ Date: _____

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PATIENT INFORMATION AND CONSENT FORM

CONSENT FOR CARE AND TREATMENT: I hereby agree and give my consent to SHARKKS Therapy to furnish appropriate rehabilitative care and treatment, as considered necessary and in the best interest in order to attend to the patient's needs. I understand that the benefits and risks to all interventions will be explained and that the patient holds the final judgment in such matters.

MEMBER DIRECT PAYMENT NOTIFICATION: Arizona state constitution permits you to pay a healthcare provider for health care services directly. If you have any active health insurance coverage, please review the provider's policies regarding payment before you make any arrangements to pay directly. By signing below, I agree to have my physical, occupational and speech therapy claims submitted to the medical insurance carrier that I have supplied.

AUTHORIZATION TO PAY: I hereby authorize insurance payment directly to SHARKKS Therapy Billing Department, 20783 N. 83rd Ave, Suite 103, Peoria, AZ 85382 for medical services rendered. I understand that I am financially responsible for the charges not covered by my insurance. In the event of default, I promise to pay collection costs and reasonable fees as may be required to obtain collection of this account.

ATTENDANCE AGREEMENT: Due To the nature of occupational, physical and speech therapy, your progress and full recovery are dependent on both our experienced therapists, and your active participation and commitment to your appointment. If you call to cancel your appointment on same day as your appointment or if you do not show, a $35.00 cancellation fee will be assessed.

WORKERS COMPENSATION PATIENTS: We are required to inform your Workers' Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.

PHOTOGRAPHY/VIDEOGRAPHY AGREEMENT: I understand that in order to protect the confidentiality of our patients, there can be no filming, going "live" via social media or taking pictures of my treatment, or that of other patients, without prior authorization from the Practice Manager.

AUTORIZATION TO COMMUNICATE ELECTRONICALLY: I understand that authorized personnel (including my physical, occupational and/or speech therapist) from SHARKKS Therapy may communicate with me regarding scheduling appointments, the treatment provided, home exercise programs, and educational/informative content as it relates to my condition. I understand that my protected health information (PHI) will not be communicated electronically. I understand that I have the opportunity to opt-out of future communications at any time using the "unsubscribe" option on any communication via text or email.

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document.

Printed Name: _____

Patient/Guardian Signature: _____ Date: _____

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PHOTOGRAPHIC CONSENT AND RELEASE FORM

I hereby consent that SHARKKS Therapy had to take or use photographs of me (and/or my property) and to use these in all media worldwide including online, now or hereafter known, and for any purposes whatsoever.

I hereby release to SHARKKS Therapy all rights to exhibit this work in print and electronic form publicly or privately and to market copies. I waive any rights, claims or interest I may have to control the use of my identity or likeness in the photographs and agree that any uses described herein may be made without compensation or additional consideration of me.

I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

Printed Name: _____

Address: _____

Phone #: _____

Patient/Guardian Signature: _____ Date: _____

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HIPPA AUTHORIZATION FOR DISCLOSURE OF PHI

I, _____ hereby consent and authorize SHARKKS Therapy and its employees, agents, partners, and affiliates (collectively "Clinic") to disclose my Protected Health Information ("PHI"), as that terM is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for marketing purposes, as stated below. I understand that subsequent disclosures by recipients of my PHI may not be protected by the HIPAA Privacy Rule or other applicable medical record privacy laws. I understand that I may revoke this authorization at any time by giving written notice to Clinic, except to the extent that Clinic and its agents, employees, and representatives may have taken action in reliance on this authorization. This authorization is effective on the date stated below for an indefinite period of time. A photocopy of this authorization form is valid and should be given the same force and effect as the original.

I hereby agree, SHARKKS Therapy may disclose any and all of my protected health information to the following individuals, all of whom are involved in my care for any purpose related to my treatment or the payment of my care.

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

_____ _____

Patient/Guardian Signature Date

SHARKKS
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20783 N. 83rd Ave Ste 103 Peoria, AZ85382
P:623-444-8880
F:623-444-9282

Dear Family:

Welcome to Sharkks Therapy. We look forward to working with you to assist your child's development, and we will make every effort to accommodate your schedule and needs. I would like to also make you aware of our cancellation, and no-show policy.

Because consistency with therapy is crucial to the success of the treatment, we encourage all families to make therapy attendance a very high priority. We ask that you schedule your other appointments around your home-based or clinic based therapy in order to be present for therapy.

In the event that you have to cancel therapy, please inform us in as much advance as possible to cancel your therapy appointment. You may text or call the therapist directly, or you may call our office at 623-444-8880.

If two or more cancellations occur in a 2-month time frame, unfortunately your designated time slot for therapy will no longer be available. Please call our scheduling department to see what other times are available.

Our no show policy is after the fist no show there will bea verbal reminder and written reminder given. After the second no show you will be discharged from services.

Thank you!

Hailee Williams

Practice Manager

Sharkks Therapy

Patient Name: _____

Parent/Guardian Signature: _____ Date: _____