MILESTONES THERAPY

speech, language, swallowing

405 Love Avenue
Tifton, GA 31794
P: 229-402-7188
F: 229-472-8169
Info@milestonestifton.com

WELCOME!

Welcome to Milestones Therapy! We look forward to working with you. Included in this packet you will find your intake paperwork. Paperwork must be completed prior to your first appointment.

If you have a copy of the following paperwork please bring it to your first appointment:

- Medical Records
- Insurance Card/Information
- Previous Therapy Records

*If you do not have copies of these documents we can assist you in obtaining them.

Please contact our office at (229)402-7188 if you need assistance completing this paperwork.

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INTAKE/CASE HISTORY

Name:		Male	Female
Date of Birth:		Age:	
Marital Status:			
Spouse or Caregiver's Name:			
Email:		Phone:	
Address:			
City:	State:	Zip Code:	

Please describe why you are pursuing speech/language/ swallowing therapy:	

Insurance Information

Insurance Name:		Effective Date:	
Policy Number:		Group Number:	
Policy Holder Name:		Policy Holder DOB:	
Secondary Insurance (if applicable):			

Medical Information/History

Primary Care Physician:			
Specialists:			
Allergies:			
Hearing:		Vision:	

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Most Recent Hospitalization & Reason:			
Surgeries/Medical Procedures:			
Please check any of the following conditions that apply:	Stuttering Voice Problems Laryngectomy. Communication Deficits Motor Speech		Swallowing Memory Loss Dementia Cognitive Deficit Hearing Loss
Please check any of the following current or past conditions that apply:	Alzheimers Cardiovascular Disease CVA (stroke) Diabetes Type I Diabetes Type II Fractures High Blood Pressure History of Cancer Huntington's		Lupus Muscular Dystrophy Obesity Parkinson's Rheumatoid Arthritis Intubation Pneumonia Tracheostomy Feeding Tube
Please list your current medications:			
Have you previously received speech/ language/swallowing therapy:	Yes No	Please indicate where and how long you received these services:	

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Please describe any other services or therapy you are receiving at this time:	
Please list any other information that may be helpful with guiding this evaluation and future treatment:	

Person Completing this form: ___________________________
Relationship to Patient: _________________________________

____ ____________________
Signature Date

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CLINIC POLICIES

We value the time we have while you are in our clinic. Your safety and well being is our top priority. Please review the following policies and procedures required to participate in services in our clinic:

- Please stay on the first floor/waiting area until your therapist arrives to take you to your session.
- Patients/children are not allowed on staircase unless traveling to and from their sessions. We are not responsible for any injuries that occur on the staircase.
- While in the waiting room please silence phones and keep noises to a minimum as to not disrupt sessions and our office staff.
- We prefer for caregivers to remain at the clinic during sessions, however, if you leave you must return at the end of your patient's session. We are no longer responsible for the patients at the conclusion of their session. If you are more than **10 minutes late** and we are unable to contact you, we may contact local law enforcement to escort your patient home.
- Caregivers/Family members- we welcome the participation of caregivers in our sessions. If more than one caregiver/family member attends with you, please recognize that you are responsible for their safety, behavior and well being while in our clinic. We ask that only one caregiver participate in a session to minimize distractions and to avoid over crowding in therapy rooms.
- Please help us care for property. Please do not allow children to move or climb on furniture.
- Children must be accompanied by an adult when using the restroom.

I have read and agree to the above clinic policies. I understand that my lack of adherence to these policies could result in discharge from services.

________________________________ ________________

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CLINIC POLICIES

Consent for Service

I authorize therapists employed by Golden Speech Therapy, Inc, to render appropriate evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time by Golden Speech Therapy, Inc. in writing. In addition, Golden Speech Therapy, Inc. may terminate services by notifying me in writing.

________________________________ ______________

Signature Date

Attendance Policy

Your participation and progress in therapy is very important to us. Consistent attendance is vital to your progress. Please adhere to the following attendance policies and procedures:

Cancellations should be made 24 hours prior to scheduled appointments. We understand that emergencies and unexpected circumstances happen, please contact our office as soon as possible if you will not make it to a scheduled appointment. canceled appointments should be rescheduled within 2 weeks.

More than 3 absences in a 3 month period will result in the loss of a recurring appointment. You will then be placed on a weekly call list. If poor attendance continues, you will be discharged from our services.

A no-show to more than 2 scheduled appointments within a 1 month period will result in loss of recurring appointments and being placed on the weekly call list. If poor attendance continues, your child will be discharged from our service.

If you are more than 10 minutes late to a scheduled appointment, the session will still end at the scheduled time or may be canceled. Please contact our office if you will be late so adjustments or rescheduling can be made.

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Assumption of Risk

I understand the risks and I hereby assert that my participation is voluntary and that I knowingly assume such risks without holding Golden Speech Therapy, Inc. and/or any employee or independent contractor employed by Golden Speech Therapy, Inc. accountable for any losses, injuries or other damages occurring to the client and/or myself. I further understand that I am fully responsible for my own safety.

_________________________________ _______________
Signature Date

Consent and Release of Photographs and Videos

By signing below I authorize Milestones Therapy to use my photos/videos for the use of educational/ teaching purposes, to monitor progress, and for promotional purposes (website, social media, press releases, etc).

_________________________________ _______________
Signature Date

Financial Disclosure

I understand that I am responsible for all costs / fees that any third-party payer (ex. insurance company, etc.) does not cover. In the event that a third-party payer source determines that rendered therapy services are "not covered" or otherwise denied, I will be responsible for all outstanding charges. I understand that I will be billed accordingly and will be responsible for payment upon specified due date. I also understand that Milestones Therapy will not become involved in disputes between you and your third-party source regarding uncovered charges or reasons for denial. I understand that if fees are not paid in full, treatment sessions may be postponed or cancelled until payment is received. Charges incurred and not paid after 60 days may be turned over to a collection agency at the client's expense. Overdue accounts may also be reported to a Credit Bureau.

Payments including session fees and co-pays, if applicable, are due at the time of service. All other payments due will be sent via electronic invoice.

Please list the email address you would like to receive invoices:______________________________

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NOTICE OF PRIVACY POLICY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may create and distribute de-identified health information by removing all references to individually identifiable information.
We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:
The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations

The right to inspect and copy your protected health information.
The right to amend your protected health information.
The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.
You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the polices and procedures of our office. We will not retaliate against you for filling a complaint.

Please contact the following for more information:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

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Acknowledgement of Privacy Policy

I acknowledge that I have received, read and understand the HIPAA Notice of Privacy Practices, given to me by Milestones Therapy. that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.
I understand that Milestones Therapy cannot disclose my health information other than as specified in the notice.

______________________________ ______________

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RELEASE OF INFORMATION

Name:		Date of Birth:	

I grant permission for Milestones Therapy to release and exchange information via written and mailed report, phone call, meeting, email, or fax to the following:

Doctor/Office	
Specialist	
Family Members	
Other	

This authorization will remain valid until written revocation of this authorization is presented.

Signature ______________________ Date ____________