COASTAL THERAPY PARTNERS

Lumberton:
210 Liberty Hill Rd.
910-272-9056

Whiteville:
108 Memory Plaza
910-207-6250

Fayetteville:
2713 Breezewood Ave
910-568-5647

Wilmington:
6770 Parker Farms Road, Suite 102
910-679-8385

PATIENT INFORMATION FORM

Child's Name: _____ _____ _____
Last First Middle Initial

DOB: _____ MALE/FEMALE (Circle one) Social Security#_____

Mailing Address: _____

Street Address/PO Box _____

City State Zip: _____ Email: _____

Parent/Guardian Name: _____

Home Phone: _____ Other Phone: _____

Emergency Contact: _____ Phone: _____

Who was child referred by: _____

Referral Agency Phone: _____

How will you be paying for your visits: _____ Insurance_____ Self Pay

Insurance Company Name: _____

Patient's ID Number: _____

Subscriber's Name: _____

Subscriber's DOB: _____ Social Security#_____

Subscriber's Employer: _____ Group #_____

***A Copy of Insurance Card is needed for our records.

***Payment/Copayments are due at time of service unless prior arrangements have been made.

COASTAL
THERAPY PARTNERS

ATTENDANCE POLICY

Our office sets aside a specific time and day for your child's therapy sessions. Successful therapy depends greatly on attendance. Therefore, Coastal Therapy Partners has the following attendance policy:

Any patient with excessive missed/cancelled appointments will be dismissed from services. Excessive missed/cancelled appointments consist of more than 3 visits missed/cancelled per month. If your current day and time does not work for you, contact our office and we will reschedule your reserved time.

Again, attendance is very important to the success of your child's therapy.

Debra Dickerson, MS, CCC-SLP Owner/President

I have read and understand Coastal Therapy Partners, Inc. attendance policy.

_____ _____

Parent Signature Date

COASTAL
THERAPY PARTNERS

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Childs Name: _____ DOB:_____

I authorize Coastal Therapy Partners, Inc. to release specified information in my record to:

Please check all that may apply:

____HEALTH DEPARTMENT

____EAR, NOSE AND THROAT PHYSICIAN

____CDSA

_____HOSPITAL

____FAMILY PHYSICIAN

____DEPARTMENT OF SOCIAL SERVICES

____REFERRING PHYSICIAN

____TEACCH

____SOCIAL SECURITY

____PUBLIC SCHOOL

____ OTHER:_____

This data shall include (please circle):

Diagnostic reports

Therapy notes/documentation

Hearing screening records

Reports from other providers/agencies

I understand this information will be used for diagnostic purposes, consultation, and for the development or revision of treatment plan. This authorization will expire one year from the date of the signature below. This doctrine of informed consent has been explained to me and I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I acknowledge that this consent is truly voluntary and that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

_____ _____ _____

Signature Relationship to child Date of consent given

COASTAL
THERAPY PARTNERS

NOTICE OF PRIVACY PRACTICES

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.

USES AND DISCLOSURES OF HEALTH INFORMATION: We seek your consent to use health information about you for treatment to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. You can revoke your consent at any time. We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purpose, for auditing purpose, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement, in specific circumstances. In any other situation, we ask for your written authorization before using or disclosing and identifiable health information. You can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policy, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, our front desk at the clinic where you are seen.

Individual Rights: In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we may charge a services fee. You also have the right to receive a list of instances where we have disclosed health information about you for reason other than treatment, payment or related administrative purposes. If you believe that information in your record or if important information is missing you have the right to request that we correct the existing information or add the missing information.

Complaints: if you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the US Department of Health and Human Services. The person listed below can provide you with appropriate address upon request.

Our Legal Duty: We are required by law to provide the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact: Alyson Nance

Coastal Therapy Partners, Inc. Patient Privacy Notice

The department of Health and Human Services has established a "Privacy Rule" ensuring that a person's health care information is protected. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosure of health information about the patient to carry out treatment, payment, or health care operation. As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precaution to protect your privacy. When it is appropriate and necessary we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or healthcare operations, in order to provide health care information and information about treatment, payment or healthcare operations, in order to provide your health care that is in our best interest. We also want you to know that we support your full access to your personal records. We may have indirect treatment with (such as laboratories that only interact with practitioners and not patients), and may have to disclose personal health information for purpose of treatment, payment or health information, but this must be in writing. Under this law, we have the right to refuse treatment should you choose to refuse all or part of your (PHI). You may not evoke action that has already been taken which relied on this or a previously signed consent. If you have objections to this form, please ask to speak with Alyson Nance, Project Manager. You may have the right to review our privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our policy notice.

Print Name_____

Signature_____ Date_____

COMPLICANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS: Coastal Therapy Partners

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and providers continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the Privacy Rule. We strive to achieve the highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate use of PHI in accordance with governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problems of improper disclosures of PHI. As part of this plan, we implemented a compliance program that we believe will help us prevent any inappropriate use of PHI. We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought to penalization if they feel that an event in anyway compromises our integrity. Moreover, we welcome your input regarding service problems so that we may remedy the situation promptly.

COASTAL
THERAPY PARTNERS

PERMISSION TO SCREEN

Patient's Name_____DOB_____
Guardian's Name_____

I, the guardian of the above patient, give permission to Coastal Therapy Partners, Inc. to screen the patient for speech-language pathology or occupational therapy services. _____ (Please initial)

I understand that this is a free service offered to determine if there is need for any future testing. _____ (Please Initial)

I GIVE Coastal Therapy Partners. permission to release this information to agencies or person involved with patient's care. _____ (Please initial)

Please List any specific concerns you have regarding the patients Speech-Language or reading development or occupational therapy services. Please feel free to call us if you have any questions.

_____
_____
_____
_____
_____
_____
_____
_____

COASTAL
THERAPY PARTNERS

SPEECH-LANGUAGE-HEARING CASE HISTORY FORM

IDENTIFYING AND FAMILY INFORMATION:

Child's Name: _____ Birthdate_____

Father's Name: _____ Daytime Phone: _____
Address: _____City, State Zip: _____
Cell Phone: _____

Mother's Name: _____ Daytime Phone: _____
Address: _____ City, State Zip: _____
Cell Phone: _____

Physician's Name: _____ Clinic: _____
Doctor's Phone: _____

Child Lives with (check one):

____Birth Parents
____One Parent
____Parent and Step Parent
____Foster Parents
____Adoptive Parents
____Other: _____

Other Children in the family:

Name	Age	Speech/Hearing Problems

CHILD'S RACE/ETHNIC GROUP:

_____Caucasian, Non-Hispanic
_____Hispanic
_____Hispanic
_____African American
_____Native American
_____ Other:_____
_____Asian or Pacific Islander

Is there a language other than English spoken in the home? _____yes _____no
If yes, what language? _____
Does the child speak the language? _____ yes _____ no
Which language does the child prefer to speak at home? _____

COASTAL
THERAPY PARTNERS

SPEECH-LANGUAGE-HEARING CASE HISTORY FORM, Continued

Speech-Language-Hearing

Do you feel your child has a speech problem? _____ yes _____ no

If so, please describe:

_____

_____

Do you feel your child has a hearing problem? _____ yes _____ no

If so, please describe:

_____

_____

_____

Has he/she ever received a speech evaluation/screening? _____ yes _____ no

If so, when and where?

_____

_____

Has your child ever had speech therapy ? _____ yes _____ no

If so, when and where? _____

Has your child ever received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.) _____ yes _____ no

If so, please explain: _____

Is your child aware of, or frustrated by, any speech/language difficulties?

_____

_____

What do you see as your child's most difficult problem in the home?

_____

_____

What do you see as your child's most difficult problem in school?

_____

_____

COASTAL THERAPY PARTNERS

SPEECH-LANGUAGE-HEARING CASE HISTORY FORM, Continued

Birth History:

Has your child had any of the following?

____adenoidectomy

____encephalitis

____seizures

____allergies

____flu

____sinusitis

____breathing difficulties

____head injury

____sleeping difficulties

____chicken pox

____high fevers

____thumb/finger sucking habit

____colds

____measles

____tonsillitis

____ear infections

____meningitis

____vision problems

____scarlet fever

____ear tubes

_____seizures.

How often:_____

Other serious injury/surgery: _____

Is your child currently (or recently) under a physician's care? _____yes ____no

If yes, why?

_____

_____

Please list any medications your child takes regularly?

_____

_____

_____

COASTAL
THERAPY PARTNERS

SPEECH-LANGUAGE-HEARING CASE HISTORY FORM, Continued

DEVELOPMENTAL HISTORY:

Please tell the approximate age your child achieved the following developmental milestones:

_____sat alone

_____said first word

_____babbled

_____spoke in short sentences

_____put two words together

_____toilet trained

_____walked

Does your child . . .

_____choke on food or liquids?

_____currently put toys/objects in his/her mouth?

_____brush his/her teeth and /or allow brushing?

CURRENT SPEECH-LANGUAGE-HEARING:

_____repeat sounds, words or phrases over and over?

_____understand what you are saying?

_____retrieve/point to common objects upon request (ball, cup, shoe")

_____follow simple directions ("shut the door or "get shoes")?

_____respond correctly to yes/no questions?

_____respond correctly to who/what/where/why/when questions?

Your child communicates using . . .

_____body language

_____sounds (vowels, grunting).

_____words (shoe, doggy, up)

_____2 to 4 word sentences

_____other: _____

COASTAL
THERAPY PARTNERS

SPEECH-LANGUAGE-HEARING CASE HISTORY FORM, Continued

BEHAVIOR CHARACTERISTICS:

_____cooperative

_____restless

_____attentive

_____poor eye contact

_____willing to try new activities

_____destructive/aggressive

_____plays alone for reasonable length of time

_____easily distracted/short attention span

_____separation difficulties

_____withdrawn

_____easily frustrated/impulsive _

_____inappropriate behavior

_____stubborn

_____self-abusive behavior

SCHOOL HISTORY:

If your child is in school, please answer the following:

Name of school and grade in school:

_____

_____

Teacher's Name:_____

Has your child repeated a grade ? _____

What are your child's strengths and/ or best subjects?

_____

_____

Is your child having difficulty with any subjects?

_____

_____

Is your child receiving help in any subjects?

_____

_____

Does your child have an IEP? If so, please bring a copy to your initial evaluation.

ADDITIONAL COMMENTS

_____

_____

COASTAL
THERAPY PARTNERS

Notice of Service

This notice is to inform you that your child's speech therapy services will be provided by a Speech-Language Pathology Assistant (SLPA). The Speech-Language Pathology Assistant is closely monitored by a licensed Speech-Language Pathologist. The Speech-Language Pathologist will test your child, write therapy goals, observe therapy sessions, review data logs, make therapy suggestions/recommendations and meet with the SLPA on a regular basis.

Coastal Therapy Partners provides excellent Speech-Language Pathology Assistant to the Robeson County, Bladen County, Cumberland County, New Hanover County and surrounding areas. We look forward to serving your child. If you have any questions or concerns, please contact our office.

Debra Dickerson, CCC-SLP/Owner

_____
Date

I understand and consent to have a Speech-Language Pathology Assistant provide services for my child.

_____ _____
Parent Signature Date

_____
Child's Printed Name

COASTAL
THERAPY PARTNERS

CONSENT TO PHOTOGRAPH

I,_____ give permission to COASTAL THERAPY PARTNERS and/or parties designated by COASTAL THERAPY PARTNERS to photograph the person named below and use such photographs in promotional purposes including advertising and correspondence with the Primary Care Physician and for the patient's chart/record. I understand that the photograph will be taken solely for the purpose of COASTAL THERAPY PARTNERS.

I understand that all information pertaining to my child(ren) and family is confidential and protected by the Privacy Act. I may revoke this consent at any time. This consent will automatically expire 1 year from the date on which it is signed.

I understand that consent for photography is voluntary and none of my rights to confidentiality or privacy are waived by my consent. I have been told and I understand that refusal to consent to being photographed will have no effect on the level or nature of care and services to which I am entitled. This consent also serves to waive all rights of compensation which I may have in connection with the use of my photograph and/or name or my child's photograph and/or name.

Check all for which you are giving permission:

_____ Social Media: Facebook, Twitter, Pinterest

_____ Electronic Medical Records

_____ Advertising

_____ Coastal Therapy Partners' company website

CHILD'S NAME_____ **DATE OF BIRTH**_____

Signed _____ **Date** _____

(Please designate if a parent, guardian, or surrogate parent)

ADDRESS_____

PHONE_____ **EMAIL ADDRESS**_____

Lumberton:	**Whiteville:**	**Fayetteville:**	**Wilmington:**
210 Liberty Hill Rd.	108 Memory Plaza	2713 Breezewood Ave	6770 Parker Farms Road/Ste 102
910-272-9056	910-679-8385	910-568-5647	910-679-8385
Fax: 910-272-9057	**Fax: 910-679-8387**	**Fax: 910-568-5864**	**Fax: 910-679-8387**

COASTAL
THERAPY PARTNERS

FINANCIAL POLICY

COASTAL THERAPY PARTNERS works proactively to deter any need to increase the cost of services provided here in our practice. Due to the high cost of billing, payment is expected on the day of your appointment. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. Coastal Therapy Partners accepts cash, personal check (in- state only), and money orders. There is a **$35.00** service charge for returned checks. If your check is returned we will no longer be able to accept checks from you.

Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling or keeping already scheduled appointments. We realize that some of our patients have financial difficulty at times. Therefore, we ask that you discuss your balance with us and make an effort to arrange payments.

Payment is expected at the time of service from whoever brings in the child for the appointment. Co-payments must be made at time of service.

INSURANCE

All insurance cards and information necessary for submitting claims to your insurance company must be provided on or before the first visit.

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 60 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges.

If you need assistance or have questions, please contact the Front Desk at the clinic listed below where your child has been treated.

REFUNDS

Overpayments will be refunded within 60 days.

MISSED APPOINTMENTS/LATE CANCELLATIONS

We reserve the right to charge $35.00 for missed or late canceled appointments. (See Policy) Excessive abuse of scheduled appointments may result in discharge from COASTAL THERAPY PARTNERS

DUPLICATE COPIES

A copy of your initial evaluation and progress reviews will be faxed to your primary care provider and given to you. Due to high demand for additional copies, there will be a charge for personal copies. Cost for copies will be $10.00. Request for any type client information to be copied, faxed, or mailed must have consent to release form signed. Copies **will not** be released if there is an outstanding balance.

Signed:_____ **Date:** _____

Signature of insured or authorized representative

Client Name _____

COASTAL THERAPY PARTNERS

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Notice of Privacy Practices (3/03)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect.

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. [If there are other such disclosures that you might make, list them here.] These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the

information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without you written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions

involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative

location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy

notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice,

must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion. we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelvemonth period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period. (6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take

(5) You have a limited right to receive an accounting of all disclosures one home with you if you wish.

(7) Minor children---medical information is discussed/given to parents or guardians

(8) Children 18 yrs and older—medical information is given only to the patient unless an "signed agreement" on file from patient that allows parents/guardian to have the information. (Unless patient is not capable of receiving their medical information, then documentation should be so noted in chart).

(9) Spouses and all other of patients—patient, medical information will not be given out to anyone unless a signed authorization is on file in patient's chart.

Protected Health Information has been presented to me By Coastal Therapy Partners.

I CONSENT to the handling of my or my child's medical information as outlined above. This consent will be valid until changed by me. All change

request require 30 day written notice sent to Coastal Therapy Partners 2713 Breezewood Avenue, Fayetteville, NC 28303 (910-488-4100)

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

COASTAL
THERAPY PARTNERS

PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ DOB: _____
(Patient)

Signature_____
(Parent/Guardian)

Print Name_____

Date_____Witness_____

COASTAL
THERAPY PARTNERS

CANCELLATION / NO-SHOW POLICY

At COASTAL THERAPY PARTNERS, we strive to provide quality speech, language and occupational therapy services to all of our clients. Our office sets a specific time and day for your child's therapy sessions. Successful therapy depends greatly on attendance. In order to be consistent and stay on schedule as much as possible, we ask that you please arrive on time for you scheduled appointment. If you need to cancel your appointment, please call 24-hours in advance or before 8:00 am on the day of your appointment. If a no-show or late cancellation occurs, Coastal Therapy Partners reserves the right to bill you **$35.00**.

Any patient with excessive missed/cancelled appointments will be dismissed from services. If three (3) appointments are missed in one month, you be discharged from our services.

If your current day and time does not work for you, contact our clinic where your child is seen and we will reschedule your reserved time. Again, attendance is very important to the success of your child's therapy.

Debra Dickerson, MS, CCC-SLP

Owner/President

I, (print name) _____, have read and understand the

Coastal Therapy Partners Cancellation/No Show Policy.

_____ _____

Signature Date

COASTAL
THERAPY PARTNERS

Demographic Information Update

I understand that I must contact Coastal Therapy Partners to update all demographic information when any changes are made. I, _____, the parent/guardian of _____ further understand by not updating information I accept full responsibility for any payments not covered by my child's insurance due to demographic information not being reported to Coastal Therapy Partners.

_____ _____

Signature Parent/Legal Guardian **Date**

_____ _____

Witness **Date**