SANTA FE therapy ASSOCIATES

Speech-Language Therapy • Occupational Therapy • Physical Therapy • Orofacial Myofunctional Therapy
1800 Old Pecos Trail, Suite #1 • Santa Fe, NM 87505
(505) 424-8777 • Fax: (505) 424-9777 • www.sftherapyassoc.com

Patient Registration Form

Patient Name_____ Date of Birth_____ Gender ( ) M ( ) F ( ) U

Address_____City_____State_____Zip_____

Cell Telephone_____ Home Telephone_____ Work Telephone_____
(Please circle the phone number you prefer for appointment reminder calls.)

Email address_____

ONLY provide the following 3 lines of information if the patient is under 18 years of age

Parent 1 Name _____ Phone Number._____

Parent 2 Name _____ Phone Number_____

Responsible party_____ Phone No._____

OTHER INFORMATION

Family Physician_____ Telephone No._____

Allergies_____

Emergency contact person and telephone #_____

INSURANCE INFORMATION
(Please give your insurance card(s) and Driver's License to be photocopied for our files).

Primary Insurance Company_____
Group No._____ Policy ID No._____

Secondary Insurance Company_____
Group No._____ Policy ID No._____

Name of Policy Holder_____ Relationship to Patient_____

I understand that I am responsible for all charges not paid by my insurance company. If my insurance claims are filed through this office, I authorize for those medical benefits to be paid to this office. I further understand that payment, co-payments and deductible payments for all services are due at the time of visit.

Signature_____Date_____

Patient Name:_____DOB:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights under the Health Insurance Portability & Accountability Act of 1996 regarding my protected health information. I understand that this information can and may be used to:

- Conduct, plan and direct my treatment and follow-up among healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been given the right to review such Notice of Privacy Practices prior to signing this acknowledgement. I understand that Santa Fe Therapy Associates has the right to change its Notice of Privacy Practices at any time and that I may contact Santa Fe Therapy Associates at any time to obtain a current copy of the Notice of Privacy Practices.

Print Name of Patient _____

Signature _____ Date _____

Relationship to Patient:
____Parent or Guardian ____Self _____Spouse _____Power of Attorney

____I want a copy of the Private Practices. **____ I do NOT want a copy.**

OFFICE USE ONLY

DOCUMENTATION OF GOOD FAITH EFFORT

_____ Attempted to obtain a signature in acknowledgement of this Notice of Privacy Practices. Patient/parent/legal guardian declined to acknowledge the receipt of same.

_____Reason for declining, if available from patient/parent/legal guardian:

Staff:_____Date:_____

INCIDENT WAIVER

Many of our young patients have attention issues and difficulty following instructions. At times, they get overly playful or excited. This creates the possibility of a rare accident or injury.

The undersigned acknowledges that Santa Fe Therapy Associates is in no way responsible for an injury or accident involving the patient of record here when that patient has been instructed not to engage in a specific activity or exercise.

_____ Date _____

Patient/Parent/Guardian signature

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PATIENT SERVICE AGREEMENT

Patient Name:_____DOB:_____
Effective January 1, 2020

CONSISTENCY:
A cancelled appointment hurts three people: you, your therapist, and another client who could have potentially utilized your time slot. When you schedule an appointment, that appointment becomes your/your child's reservation of time. Once that appointment is made, you must commit to being here. It is a shared commitment, which will only work if both parties take it seriously. Frequently missed therapy sessions result in a lack of progress for your child. **We encourage you to re-schedule cancellations.** Our clinic operates on the premise that every patient's appointment is the number one priority for both patient and therapist.

Our therapists will do everything possible to alter or accommodate scheduling provided that parents or patients give us a **minimum of 24-hours notice, and preferably 48 hours**. Without notice of 24-48 hours our therapists cannot fill those times with make-up sessions for other children and adult patients.

Consistency is essential to you/your child's success with therapeutic goals. The primary purpose of our clinicians is to treat and advocate for you and/or your child. If we begin to see a lack of commitment to therapy (i.e. inconsistent attendance or poor follow through with home programs), we reserve the right to place your child back on the waitlist or discharge your child from services.

CANCELLATIONS:

If you have to cancel a scheduled appointment it is our recommendation that you cancel with both the front desk AND your therapist.

If you need to cancel an appointment, please attempt to schedule a make-up with your therapist within the week to maintain consistency. If you do not give the front desk or your therapist at least a **24 hours** notice when you need to cancel, it will be considered an "Insufficient Cancellation."

After **two (2) non-emergency cancellations in a two month period of time, or chronic non-emergency cancellations** you/your child's appointment time will be offered to others on our Waiting List.

Examples of non-emergency cancellations:

- Vacations
- Pre-planned doctor's appointments
- Family events
- Parties
- Recreational events
- Lack of baby-sitter
- Car trouble, etc….

Examples of emergency cancellations:

- Illness
  - Fever of a 100+ in past 24 hour
  - Strep throat
  - Diarrhea
  - Skin infections
  - Eye infections
  - Vomiting more than twice in the past 24 hrs.
  - Lice
  - Accidents
- Death in the family
- Illness of a family member
- Non-planned doctor appointments
- Severe weather

Cancellations due to transportation problems are considered absences except in the instance of severe weather. In some instances, exceptions may be considered.

NO SHOWS/INSUFFICIENT CANCELLATION NOTICE:

If there are **two (2) no-shows or insufficient cancellations**, your child will be discharged unless arrangements with the office manager are made immediately to improve the situation. A "No Show" is when you fail to contact us or attend an appointment. An insufficient cancellation is a cancellation made with less than 24 hours notice. The fee for a No-Show/Insufficient Cancellation is **$60** that must be paid before your next therapy session. This fee will be charged regardless of the insurance policy the patient uses. **This fee is strictly a patient responsibility and is not billable to insurance.** If you are not able to make the payment, please contact the Office Manager in order to make payment arrangements.

By signing this document you acknowledge that you are aware of these policies and agree to abide by them.

_____ _____

Patient/Parent/Guardian Signature **Date**

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Patient Service Contract

Patient Name:_____DOB:_____

INSURANCE DEDUCTIBLE, COPAY, and CO-INSURANCE

I understand that I am responsible for payment of insurance deductibles as it relates to therapy sessions until my insurance deductible amount is satisfied. I understand that I am responsible for payment of copay and co-insurance in accord with my insurance plan(s).

_____
Patient/Parent/Guardian Signature Date

INSURANCE DENIAL POLICY

If all insurances refuse to pay for services rendered, I agree to pay $200.00 per hour for Evaluation, $75.00 per 30-minute therapy session, plus applicable Gross Receipts Tax. Details of payment will be made before continuing services. Services can be denied due to lack of payment. The patient/guardian is responsible to resolve with the insurance company any disputes regarding payment. If you feel that this fee creates a financial hardship, please contact the Office Manager to discuss.

_____
Patient/Parent/Guardian Signature Date

PRIVATE PAY (ONLY FOR UNINSURED PATIENTS)

I agree to pay $200.00 per hour for Evaluation, $75.00 per 30-minute Therapy session, or $150.00 for and hour, plus applicable Gross Receipts Tax. If you feel that this fee creates a financial hardship, please contact the Office Manager to discuss.

_____
Patient/Parent/Guardian Signature Date

Patient Name:_____DOB:_____

AUTHORIZATION TO PHOTOGRAPH

Santa Fe Therapy Associates has my permission to photograph, film or tape activities in which the client is participating. These photographs will only be used for demonstrating progress.

_____

Patient/Parent/Guardian Signature Date

AUTHORIZATION FOR MUTUAL EXCHANGE OF RECORDS/INFORMATION:

Our services must be followed by a Primary Care Physician and a current referral must be on file.

I AUTHORIZE THE EXCHANGE OF INFORMATION BETWEEN SANTA FE THERAPY ASSOCIATES AND:

(Name of primary care physician) _____

(Name of parent or guardian) _____

(Other entities, by name)

_____

_____

All records will be protected by confidentiality among these entities.

_____

Patient/Parent/Guardian Signature Date

CONSENT FOR EMAIL:

I consent to receive emails for :

- Records
- Receipts
- Statements

_____

Patient/Parent/Guardian Signature Date