Milestone Pediatric Therapy Services, Inc
514 Panther Drive Jefferson, GA 30549
Phone: 706-367-1141 Fax: 706-367-1142

Intake Form

Patient Name: _____Gender: M F DOB: _____

Address: _____

Cell #:_____ Home#:_____ Email:_____

Physician name and number: _____

Primary Insurance

****YOU ARE RESPONSIBLE FOR KEEPING YOUR UPDATED INSURANCE ON FILE WITH OUR OFFICE- PLEASE GIVE US NEW INSURANCE CARDS AS SOON AS THEY ARE AVAILABLE. CHARGES MAY BE ACCRUED IF WE ARE NOT GIVEN UPDATED INSURANCE INFO.*****

Insured's Name: _____ relationship: _____ DOB: _____

Insurance Company: _____Insurance ID: _____

Insurance Address: _____

Group /Account #: _____Insurance Phone #: _____

Policy Holder's Place of Employment: _____

CHECK ONE IF APPLICABLE: Medicaid:____ Amerigroup: ____Peachstate:____Caresource:____

I hereby consent that all information provided on this form is true to the best of my knowledge.

_____ _____ _____
Parent/Guardian (print name) Parent/Guardian signature Date

AUTHORIZATION TO SEND TEXT MESSAGES/EMAILS

By signing this form, I authorize Milestone Pediatric Therapy staff to send text messages to my cell phone and/or emails to convey information regarding my child _____ I understand that standard text messaging rates will apply to any messages received from Milestone Pediatric Therapy. I also understand that I or Milestone Pediatric Therapy may revoke this permission in writing at any time. I agree not to hold Milestone Pediatric Therapy liable for any electronic messaging charges or fees generated by this service. I further agree that in the event my cell phone number and/or email changes I will inform Milestone Pediatric Therapy.

Patient Name: _____

Parent Name: _____

Parent Signature: _____

E-Mail Address: _____

Cell Phone #:_____

FINANCIAL AGREEMENT

I understand that my insurance is a contract between the insurance carrier and me, and not between the insurance and Milestone Pediatric Therapy Services, Inc, and that I am still fully responsible for all fees my insurance carrier does not pay. These fees are due and payable via cash, check or credit card at the time services are rendered, unless a prior financial arrangement has been made and is in writing by Milestone Pediatric Therapy Services, Inc and signed by myself.

_____ _____ _____

Patient/Legal Guardian Signature Patient Name Date

_____ _____

Witness Date

Acknowledgement of Notice of Privacy Practices and General Privacy Consent

I hereby certify that I have received a copy of the Milestone Pediatric Therapy Services Notice of Privacy and Practices with an effective date of January1, 2008. I am aware and acknowledge that this Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that I may direct any questions, concerns, or complaints about the privacy practices of Milestone Pediatric Therapy Services to the company's Chief Privacy Officer at 706-367-1141.

I am also aware that my home health treatment requires that a copy of my clinical record, containing protected health information, be kept in my home. I have been advised and agree that the protection and security of my in-home clinical record remains my responsibility; and I must be diligent to prevent persons not entitled or authorized to view this information from accessing it.

By virtue of this document, I am also giving my consent to Milestone Pediatric Therapy Services, and/or its operating subsidiaries to use and/or disclose my protected health information for the purposes of treatment, payment and operations. I understand that Milestone Pediatric Therapy Services may in the course of rendering care to me, disclose personal health information about me to my family, close friends, or any other person that I identify as long as the information disclosed is relevant to their involvement in my care or payment of my care. I understand that I may opt-out or otherwise restrict the disclosure of my information to such persons providing notice to Milestone Pediatric Therapy Services.

_____ _____

Signature (Parent/Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date

_____

Witness

PATIENT AUTHORIZATION

All information provided herein is true and correct

I am aware of my diagnosis and wish to receive treatment at this time. Milestone Pediatric Therapy Services, Inc. or affiliated company. I permit its employees and all other person(s) caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of said care.

I give permission to Milestone Pediatric Therapy Services, Inc and its subsidiaries and affiliates to release information verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and /or beneficiaries and all other related persons as it relates to my treatment.

I authorize Milestone Pediatric Therapy Services/or its subsidiaries and affiliates to obtain medical records and/or professional information from my physician or other professional as it relates to my treatment.

Please check one:

- ☐ I allow for my/my child's photographs and/or video taken at Milestone Pediatric Therapy Services to be used in promotional materials for the clinic including social media.
- ☐ I DO NOT allow my/my child's photographs and/or video taken at Milestone Pediatric Therapy Services to be used in promotional materials for the clinic including social media.

_____ _____

Signature Date

_____

Print Name

_____

Patient Name

******APPOINTMENT CANCELLATION POLICY******

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for schedule appointments to be **cancelled by the night before** your appointment by either calling or texting the therapist you are to seeing. If you do not have their number, please leave a message on the office phone **706-367-1141.**

Our therapists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, or is more than 15 minutes late, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments not cancelled the night before. As of February 1st, 2020 there will be a fee of **$10.00** assessed if we do not receive a call to cancel an appointment or you are 15 minutes late.

3 no-shows in a 3 month period of any combination of therapy services, will result in 6 months off the appointment schedule.

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy enables us to open otherwise unused appointments to better serve the needs of all patients.

Patient Name: _____

Parent Signature: _____

Date: _____

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Release of Information Form

Date: _____

Child's Name: _____

DOB: _____

Records Requested From: _____

Phone: _____

Fax: _____

Records Requested: _____

_____

I hereby authorize the release of records listed above, in reference to my child, _____, to Milestone Pediatric Therapy Services, Inc. I understand that confidentiality will be maintained as no further distribution of the material will be completed without further written consent.

Signature of Parent/Guardian:_____

Printed Name: _____

Date:_____

Telehealth Member Consent Form
PATIENT NAME:
DATE OF BIRTH:
GA MED ID#_____

1. PURPOSE: The purpose of this form is to obtain your consent to participate in a telehealth consultation in connection with the following procedure(s) and/or service(s):

_____
_____

2. NATURE OF TELEHEALTH CONSULT: During the telehealth consultation:
a. Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
b. A physical examination of you may take place.
c. A non-medical technician may be present in the telehealth studio to aid in the video transmission.
d. Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s)

3. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient- identifiable images or information for this telehealth interaction to researchers or other entities shall not occur without your consent.

4. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth consultation, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during this telehealth consultation.

5. RIGHTS: You may withhold or withdraw consent to the telehealth consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

6. DISPUTES: You agree that any dispute arriving from the telehealth consult will be resolved in Georgia, and that Georgia law shall apply to all disputes.

7. RISKS, CONSEQUENCES & BENEFITS: You have been advised of all the potential risks, consequences and benefits of telehealth. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telehealth consultation. All your questions have been answered, and you understand the written information provided above.

I agree to participate in a telehealth consultation for the procedure(s) described above.

Signature: _____Date: _____

Relationship to Patient: _____

Witness Signature: _____ Date: _____