Therapeutic Designs & Services
Occupational · Speech · Academic · Physical Therapy

We would like to welcome you to Therapeutic Designs and Services! We want to make your visit as comfortable and stress free as possible. To make this possible we are asking that you fill out the enclosed referral history forms.

We also need the following evaluations, if you have them:

Psychological
Medical
Speech
Occupational Therapy
Physical Therapy

We like to have the evaluations prior to your visit. This allows us time to be familiar with your child's history, as well as providing you with better service.

Please return the forms along with any copies of previous evaluations. We will also need a copy of your insurance card, (front and back). You will need to have an Occupational therapy or Speech therapy prescription prior to scheduling an appointment.
We look forward to meeting and working with you!

If you do not have coverage with your insurance company, payment is expected at the time services are rendered. We accept cash or credit/debit card payments.

If you have any questions, feel free to call us at 843-332-3600 or text us at 843-858-8216.
Please arrive at least 15 minutes early for your first visit to fill out any additional paper work.
Thank you,

Irene R. Ingram, OTR/L

PO Box 1923 • Hartsville, South Carolina 29551 • Phone 843-332-3600 • FAX 843-332-1314. Cell 843- 858-8216
Email: ireneingramotrl@gmail.com

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Medical and Sensory Motor History for Occupational Therapy-
For Evaluation of Sensory Integration and Praxis Profile

PATIENT INFORMATION FORM

REFERRAL DATE:_____

PARENT NAME: _____

PATIENT NAME:_____

E-MAIL:_____

ADDRESS: _____

HOME NUMBER:_____ CELL NUMBER: _____

DATE OF BIRTH: _____

DIAGNOSIS: _____

REFERRING AGENCY: _____

PHYSICIAN'S NAME: _____

NAME OF INSURANCE:_____

IS YOUR CHILD BEING SEEN AT ANOTHER FACILTY? IF SO, FOR WHICH

SERIVCE OT OR ST? _____

CHECK IF PARENT WAS INFORMED ABOUT THE FOLLOWING WHEN CALLED:

_____ INSURANCE AND MEDICAID POLICY. PATIENT CAN PAY FOR EVALUATION IF THEY CHOOSE. EVALUATION IS 300.00 (2 HR. APT.). 1 HR. VISITS AFTER EVALUATION IS 100.00.

_____ WILL NEED DR'S ORDER AND ANY RECORDS AND REPORTS

_____I WILL BE SENDING REFERRAL FORMS THAT NEED TO BE SENT BACK AND TEACHER REFERRAL FORM

NOTES:

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____ hereby authorize Therapeutic Designs and Services to release videotaping of occupational therapy sessions including any information which may comprise or contain "Protected Health Information" (PHI) under the Health Insurance Portability and Accountability Act (HIPAA), to the participants attending the workshop.

I understand that this Authorization is executed for a workshop instructed by Therapeutic Designs and Services. I
also understand that Protected Health Information will be released for purposes related to that matter.

This videotaping will only be used for workshops and educational purposes instructed by Therapeutic Designs and Services. Therapeutic Designs and Services will be the sole users of this videotape; any other use is prohibited without written permission.

I also understand that the PHI may be subject to state and federal law, but I expressly authorize the release of such information as specified herein. I understand that once this information is released, Therapeutic Designs and Services can no longer control or be responsible for its use or re-disclosure. Once released, the information may no longer be protected under HIPAA.

I may revoke this Authorization at any time except to the extent that Therapeutic Designs and Services has taken action in reliance upon it. In order to revoke this Authorization, I must submit a written request to Privacy Official at the address set forth below.

If I have any questions or complaints, I understand that I may contact the Privacy Official at 866-627-7748, or at the address listed below. In addition, if I have a complaint, I may inform the Centers for Medicare and Medicaid Services at HIPAA Compliant, 7500 Security Blvd., C5-24-04, Baltimore, MD 21244.

Dated: _____

Patient Name: _____

Parent Signature: _____

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize Therapeutic Designs and Services to release medical information including any information that may comprise or contain "Protected Health Information" ("PHI") under the Health Insurance Portability and Accountability Act (HIPAA").

I understand that this Authorization is executed for reasons stated in the Policy and Procedures guidelines, and PHI will be released for purposes related to these matters.

I hereby acknowledge the receipt of the Notice of Privacy Practices, on the date set forth below. I understand that this Notice of Privacy Practices contains important information about my health information and that I should review the Notice of Privacy Practices.

I also understand that the PHI may be subject to state and federal law, but I expressly authorize the release of such information as specified herein. I understand that once this information is released, Therapeutic Designs and Services can no longer control or be responsible for its use or re-disclosure. Once released, the information may no longer be protected under HIPAA.

I may revoke this Authorization at any time except to the extent that Therapeutic Designs and Services has taken action in reliance upon it. In order to revoke this Authorization, I must submit a written request to Privacy Official at the address set forth below. If not previously revoked, this Authorization will expire on date of discharge.

If I have any questions or complaints, I understand that I may contact the Privacy Official at (843)-332-3600, or at the address listed below, first. In addition, if I have a complaint, I may inform the United States Office of Civil Rights, Medical Privacy Complaint Division, U.S. Dept. of Health and Human Services, 200 Independence Ave., South West, HHH Building, Room 509H, Washington, DC 20201, or call 866-627-7748.

Dated: _____

Patient Name: _____

Signed: _____
(Patient, Parent, or Guardian)

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Permission Form

I give Therapeutic Designs and Services permission for _____,
to receive Occupational Therapy and/or Speech Therapy Services.

_____ _____

(Signature) (Date)

Responsible Party Form

I am responsible for paying co-pays, co-insurance and deductibles at Therapeutic Designs and Services. Payment is due at the time of service. I am responsible for keeping track of the amount of visits allowed by my insurance company and will be responsible for payment in full for services rendered when this limit has been reached. Therapeutic Designs and Services will notify me when they are made aware that my limit has been reached.

_____ _____

(Signature) (Date)

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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

_____

(Client Name) **(Date of Birth)**

I, _____, authorize Therapeutic Designs and Services
(Parent Name)

to disclose or receive information from:

_____

(Person or organization to whom disclosure is made and information received)

The following information may be discussed:

_____

(Please be as specific as possible)

The purpose of receiving or disclosing this information is to aid in the treatment of your child.

I give permission for the release of information in the following forms:

[] written [] verbal [] fax [] conference or observation [] other

_____

(Client Name)

_____

(Parent or Guardian Signature) **(Date)**

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AUTHORIZATION AND CONSENT FOR TREATMENT AND MEDICAL EMERGENCY RELEASE FORM

I _____, consent for Irene Ingram and/or staff of Therapeutic Designs and Services, Inc. to access and obtain medical services appropriate for the emergency medical care of my child _____, in my absence.

I hereby, authorize for the emergency transport of my child to the nearest emergency medical facility should this be deemed necessary.

I also authorize in my absence, the emergency department authority to provide immediate and appropriate medical services and treatment of my child's injury or illness.

My signature below authorizes parental consent of medical information compliant with HIPPA regulation for my child, _____.

Signature _____ (Relationship) _____

Date _____

Medical Information and Conditions:

Allergies:

Emergency Contact Numbers:

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CANCELLATION POLICY

This office requires a 24-hour notice for all cancellations. We appreciate your business and to better serve you, we need all appointments appropriately managed. For this reason, any cancellations without 24-hour notice will result in a $60.00 personal charge. You may notify us by any of the following methods:

Email: ireneingramotrl@gmail.com

Office cell: 843-858-8216- text and/or call

Office phone 843-332-3600

Please leave us a message by your preferred method 24 hours in advance. We appreciate your cooperation in this matter and thank you for your business.

I have read and understand this policy.

_____ _____

(Sign) (Date)

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Scheduling Information

Childs Name_____ Today's Date_____

Please X out boxes that are times you can have an appointment. We have a busy schedule
and need to know all options.
What is your driving time to this office? _____min _____hours

	Monday	Tuesday	Wednesday	Thursday
8:00				
9:00				
10:00				
11:00				
12:00				
1:00				
2:00				
3:00				
4:00				
5:00				
6:00				

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RELEASE FOR APPOINTMENT REMINDERS

I, _____ (Print), hereby authorize "Therapeutic Designs and Services" to send me an appointment reminder via e-mail or text message using the following information.

Email reminders may contain patient or clinic information such as, but not limited to, patient first name and clinic location.

Patient / Guardian Contact Information:
(Please print clearly and legibly)

E-mail: _____

Cell phone: _____

Child's Name / Patient (Print): _____

Signature: _____

Date: _____

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Email: ireneingramotrl@gmail.com

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ . _____ 3. _____ . _____

2. _____ . _____ 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.