Ann Tubre, LOTR
Karl Kaufman, PT
Christi Holt, M.A., CCC-SLP

GLORY THERAPY

believe and achieve

810 North 29th St.
Monroe, LA 71201
Office (318)600-4260
Fax (318)600-4268

Physical Therapy, Occupational Therapy, & Speech Therapy

www.glorytherapy.com www.facebook.com/GLORYTHERAPY

PATIENT REGISTRATION FORM

Patient Name: _____

Phone Number: _____ Can we text? If so, Phone Number: _____

Address: _____ City state zip: _____

Patient DOB: _____ Age: _____ Male: _____ Female: _____ Patient SS# _____

Patient student status: Full Time: _____ Part Time: _____ Name of school: _____

Email Address: _____

Emergency Contact _____ Phone Number: _____

Physician: _____ Diagnosis: _____

Are you currently receiving Home Health? Y N If yes, from who? _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Relationship to Patient: _____

Address: _____ City state Zip: _____

Resp. Party DOB: _____ Age: _____ Male: _____ Female: _____ Resp.Party SS# _____

Phone Number: _____ Work Number: _____

Employer: _____

INSURANCE INFORMATION

Insurance Name: _____ Insured Name: _____

Address: _____ Group Number: _____

_____ ID Number: _____

_____ Claim Number: _____

Phone Number: _____ Insured DOB: _____

Fax Number: _____ Relationship: _____

Next Page

HOW DID YOU HEAR ABOUT US?

Who referred you to Glory Therapy? _____

If no one referred you, how did you hear about us? _____

APPOINTMENT NOTICE

Would you like to receive texts messages to remind you about your appointment or child's appointment? Y N

Patient's Name: _____ The number that receives the text: _____

Phone Provider: _____ Phone Provider Example: AT&T, Verizon

CANCELLATION POLICY

A mandatory 24 hour cancellation notice is required to avoid a $50 cancellation/no-show fee to the client, NOT the insurance carrier. The cancellation fee will be charged to your card on file. Three (3) consecutive cancellations or no-shows may result in the loss of your scheduled therapy appointments. Please call the office to cancel your appointments so that our scheduler can let all effected therapists know about the cancellation. Please note that we do understand circumstances beyond your control. This policy is set in place to protect all parties involved and to respect your time and the business time. We appreciate your understanding and cooperation concerning this matter.

In order to file claims to your insurance, we must have complete information. We cannot file an insurance claim unless all information is received. By signing below, you are stating that you have read, completed, and understand all information requested on this form.

Please Sign:_____ Date: _____

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Please call the office to cancel your appointments so that our scheduler can let all effected therapists know about the cancellation.

Please note that we do understand circumstances beyond your control. This policy is set in place to protect all parties involved and to respect your time and the business time. The cancellation fee will be waived if a doctor's excuse is presented at the next scheduled appointment. We appreciate your understanding and cooperation concerning this matter.

Signature: _____

Date: _____

Please fill out the details as indicated below

Card Holders Name: (Exactly as it appears on card)

_____

Card No: _____ Expiration Date: _____

Security Code: _____ Zip Code: _____

Card Type: Visa [ ] MasterCard [ ] Discover [ ]

Card Holders Signature: _____ Date: _____

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OFFICE FINANCIAL POLICY

Payment is due at the time services are rendered. For your convenience we accept cash, credit cards, personal check, money order, or registered check. Also GLORY THERAPY LLC, Ann Tubre LOTR, and Christi Holt MA CCC-SLP have partnered with Care Credit. Care Credit gives you flexibility and convenience when managing your family's out-of-pocket healthcare expenses. You may find more information at www.carecredit.com or call 800-365-8295.

Insurance benefits are determined by your employer. **Any deductible or estimated co-payment amount will be due at the time of treatment**. Please provide us with your most current insurance information so that all claims for therapy visits are processed in a timely fashion. Insurance is not a guarantee of payment; insurance companies don't necessarily pay for all your costs. Your insurance policy is a contract between you and your insurer. Your insurance and payment is viewed as your responsibility. **If payment for services already rendered has not been paid, either by you or your insurance company, the remaining balance for treatment is considered due and collectible as patient responsibility.**

We reserve the right to charge and collect fees for broken appointments. See cancellation policy. **Patient will receive a $50 cancellation fee** if appointment that is reserved exclusively for the patient has been broken and cancellation policy is violated.

Returned Check Fee of $40 will be added to your account balance and is collectible.

All Medicare patients will need to sign an Advance Beneficiary Notice of Noncoverage (ABN) before Patient Therapy Cap is reached.

For bookkeeping purposes payments must be paid to the individual providers as follows: Speech Therapy – Christi Holt MA CCC SLP, LLC; Occupational Therapy – Ann Tubre, LOTR, LLC; and Physical Therapy – GLORY THERAPY LLC.

I have read and understand this financial policy.

Patient Name: _____ Signature_____

Print Name: _____ Signature: _____
**If Patient is a minor or Person Responsible for patient
Relationship to patient_____ Date: _____

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Photo/Video Release Form

I, _____, hereby authorize Glory Therapy to use, reproduce, and/or publish photographs and/or video that may pertain to the patient, _____, including their image, likeness and/or voice without compensation. I understand that this material may be used in various publications or internet websites (including but not limited to www.glorytherapy.com and Facebook). This authorization is continuous and may only be withdrawn by my specific rescission of this authorization.

Signature: _____

Printed Name:_____

Relationship:_____

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PATIENT AUTHORIZATION FORM FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the use or disclosure of _____'s individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that he released information may be subject to re-disclosure by the recipients and no longer be protected by federal privacy regulations.

Patient Name: _____ Parent/Guardian: _____

Relationship to signee: _____ Signature: _____

Persons/Organizations providing the information:

Name: _____

Address: _____

City/State/Zip: _____

Persons/Organizations receiving the information

Glory Therapy, LLC
810 North 29th St. Monroe, LA 71201

Ann Tubre, LOTR, LLC
810 North 29th St. Monroe, LA 71201

Christi Holt, M.A.,CCC-S
810 North 29th St. Monroe, LA 71201

Specific description or information (including dates):

_____

What is the purpose of use or disclosure of patient information?

_____

The patient or the patient's representative MUST read and initial the following statements:

1. I understand that this authorization will expire on ____/____/____(MM/DD/YEAR)

If I fail to specify an expiration date, this authorization will expire 12 months from the date signed or after this event.

Initials_____

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but If I do, it will not have any effect on any actions takes before receiving the revocation.

   Initials _____

3. I understand that I may refuse to sign this form and that my health care and the payment for my healthcare will not be affected if I do not sign this form.

   Initials _____

_____

If a patient representative signs this authorization, please complete the following:

Signature of patient's representative: _____

Relationship to the patient: _____

Describe the representative's authority to act for the patient: _____ Effective: _____(MM/DD/YY)