Achieve Therapy Services,LLC
2040 Highway A1A, Suite 203, Indian Harbour Bch, FL 32937
achievetherapy.org
(321) 773-8989
(321) 773-8990 fax

Client Registration Form

This Information is about the Client

Last Name	First Name	Middle Name
Date of Birth / Sex / Relationship to Guarantor		Social Security #
Address	Home Phone	Email Address
City	State	Zip Code
Primary Care Physician	Phone	

Name of Parent	Name of Other Parent with Shared Parental Responsibility/ Custodial Rights
Address if different than Child	Address if different than Child
Telephone Numbers * ☐ Home _____ ☐ Work _____ ☐ Cell _____ *Check phone numbers we may call for appointments or other office contacts	Telephone Numbers * ☐ Home _____ ☐ Work _____ ☐ Cell _____ *Check phone numbers we may call for appointments or other office contacts

Names of persons who may receive general information about the child:
Check those that apply.

☐ Primary Care Physician _____
☐ _____
☐ _____
☐ _____

MEDICAL INSURANCE INFORMATION/PAYMENT INFORMATION

Primary Insurance Co. or Person Responsible for Bill	Policy Number	Group Number
Claims Address		Effective Date
Guarantor Name	Guarantor SS#	Guarantor Date of Birth
Secondary Insurer or Person Responsible for deductibles/copays	Policy Number	Group Number
Claims Address		Effective Date
Guarantor Name	Guarantor SS#	Guarantor Date of Birth
Employer	Employer Phone	

Occupational/Speech Therapy

Your child has been referred for Occupational/Speech Therapy. The information below is offered to help you understand our policies and responsibilities.

You will need to do the following:

- Obtain a prescription from your child's primary care physician for "Occupational/Speech Therapy Evaluation and Treatment".
- Using the registration form attached, provide us with information regarding funding for Occupational/Speech Therapy (i.e., Private Insurance, Medicaid, self-pay, etc.)

Please refer to the "Notice of Privacy Practices". We are required to provide you with a copy. It details how we handle your Protected Health Information as required by the new HIPAA legislation.

Once the prescription is received and authorizations are obtained, an evaluation will be completed to determine service needs.

Services will be billed monthly: We accept private insurance, Medicaid, cash, or personal check. Returned checks are subject to a service charge of $25.00.

Medicaid: Authorization must be obtained from your Primary Care Physician before any services can be provided. Please notify us immediately of ANY changes to your Medicaid benefits. Failure to do so may result in the account becoming a self-pay.

Insurance: Your insurance policy is a contract between you and your insurance company. We will contact your insurance company in order to assist in predetermining benefits. However, the information provided to us by your insurance company is not a guarantee of payment or authorization of service; it is a summary of plan benefits.
Even though you have insurance, you are still responsible for payment in that you must make every effort to keep up with the requirements of your insurance contract to ensure that we receive payment for the services we provide.

If you reach your maximum coverage for your policy for the year, the account will revert to self-pay until such time that your benefits are refreshed for a new year or you have made arrangements to extend your coverage with the current policy or a new one. You must inform us of ANY change in insurance coverage so we can call to verify coverage and benefits.

Release of Information: I hereby authorize the use or disclosure of my protected health information concerning diagnosis and/or treatment when requested by a party for its use in determining a claim for payment for that treatment and/or diagnosis. I permit a copy of this authorization to be used in place of the original, which is on file with Achieve Therapy Services. This authorization will remain in effect until revoked by me in writing.

I hereby authorize my insurance benefits to be paid directly to Achieve Therapy Services for any services provided. I understand that I am financially responsible for any and all charges relating to non-covered services. If it becomes necessary to collect any sum due through an attorney or collection agency, then the patient agrees to pay all reasonable costs of collection, including but not limited to attorney's fees, whether suit is filed or not.

Permission to Treat: I hereby give my permission to receive treatment from Achieve Therapy Services.

I have read the information above and agree with the terms and conditions.

Client Name _____ Date _____

Print Responsible Party Name _____ Sign Responsible Party _____