340 East Sunset Way, Suite 101
Issaquah, WA 98027
(425) 557-6657

Patient Registration

Child Information

Patient/Child Full Name: ______ Date of Birth: ______

Father: ______ Mother: ______

Father Cell Phone: ______ Mother Cell Phone: ______

Father Email: ______ Mother Email: ______

Address: ______ City: ______ State: ______ Zip: ______

Home Phone: ______ Diagnosis: ______

Primary Areas of Concern: ______

Other professionals working with child: ______

Educational Services: ______ School Phone: ______

Physician First Name: ______ Last Name: ______

Physician Phone: ______ Referral Source: ______

Medical Conditions & Allergies: ______

Insurance Information *(Please provide insurance card)*

Primary Subscriber's Full Name: ______ Date of Birth: ______

Billing Address: ______

Employer: ______ Profession: ______

Work Phone: ______ Insurance: ______

Group#: ______ Individual#: ______ Secondary Insurance: ______

Assignment and Release

I understand that I am financially responsible for payment to Lisa Hamblin and Sammamish Children's Therapy for services not covered by my insurance company. I authorize medical benefits to be paid directly to Lisa Hamblin or Sammamish Children's Therapy. I authorize Lisa Hamblin and Sammamish Children's Therapy to release information required for the claim.

Signature: ______ Date: ______

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Release of Information Form

Patient/Child's Full Name: ______________________________

Date or Birth: ______________________________

Father: ______________________________

Mother: ______________________________

Phone: ______________________ Alternative Phone: ______________________

I authorize release of speech-language pathology records (treatment notes, evaluation reports, phone consultation regarding treatment and pertinent questions) to be released to the following, unless cancelled by patient (no expiration date):

Name: ______________________________

Organization: ______________________________

Phone: ______________________________

Permission to Fax: Yes: No: ______________________________

Permission to Email: Yes: No: ______________________________

Signature: ______________________ Date: ______________________

sammamish children's therapy

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Financial Policy

We at Sammamish Children's Therapy are committed to providing the highest level of speech and language care to our patients. We ask that parents or guardians take responsibility to meet their financial obligations. We see patients from many different insurance plans and it is impossible for us to know all the covered benefits, co-pays, and deductibles for each plan. While we want to assist, it is your responsibility to ensure that all services rendered are paid in full. In order to clarify, our requirements are listed below:

Appointments

24 hour notice is expected if you need to cancel or reschedule your appointment. Missed appointments without 24 hour notification will be charged a $50 no show fee (This fee is not submitted to insurance).

Financial Responsibility

You, the patient (or the patient's guarantor), are ultimately responsible for all charges associated with your care regardless of insurance coverage. Co-payments and deductibles are a contract responsibility between the patient and their insurance. Some insurance companies require a doctor's referral or pre-authorization before treatment will be covered. If you are unsure of your insurance coverage, please consult with your insurance company.

Patients Without Insurance Coverage:
Payment at the time of service is required unless other arrangements have been made. A 10% discount will be given to account for the reduced administration time necessary to process these claims.

Participating Insurances

We participate with a variety of insurance plans. It is your responsibility to:

- Verify with your insurance that we are a contracted provider
- Bring your insurance card and picture ID to every visit
- Be prepared to pay your co-pay before each visit
- Bring any required referral or authorization for treatment prior to or at the time of your visit

Additional Charges

For checks returned for non-sufficient funds, a $35.00 fee will be charged to your account.
A service fee of $10 will be charged monthly on all balances not paid in full after 30 days unless prior arrangements have been made. If payment arrangements have been made and arrangements are not being honored, your account will be turned over to our collection agency after 60 days.

Signature: ______________________________ Date: ______________

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Acknowledgment of Practices and Agreement of Adherence

As an associate (employee, educator, therapy aide, colleague or any other associated business personnel) working with Sammamish Children's Therapy, I acknowledge the following:

All health information is confidential and is to be used for stated uses as outlined by our Notice of Privacy Practices. I agree to treat all information that I come in contact with or that is shared with me as confidential.

Further I acknowledge I have read and understand SCT Privacy Practices.

If I am a service provider and information is requested to be shared with other facilities I am aware that it requires a signed Mutual Exchange of Information from the patient or guardian and that such exchange should be documented in the clients chart.

Signature: ______________________________ Date: ______________

Credentials/ Position: ______________________________

Print Name: ______________________________

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Cancellation Policy

24 hour notice is required for therapy cancellations otherwise your account will be charged a $50 fee to cover the expense of the therapist. Sickness and emergencies are excluded from the cancellation fee.

Please print your name: ______________________________

Please print child's name: ______________________________

Signature: ______________________________ Date: ______________

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Emergency Contact Information

Emergency Parent/Guardian Contact Information

Full Name: ____________________

Cell phone number: ____________________

Alternative Person

Full Name: ____________________

Cell phone number: ____________________

I give permission for emergency medical treatment in my absence

Signature: ____________________

Patient's Doctors Information

Doctor's name: ____________________

Doctor's number: ____________________

Patient Information

Allergies: ____________________

____

Medical Conditions: ____________________

____

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Authorization of Electronic Statements

Your statement will automatically be sent to the email address on file, unless otherwise noted.

Thank you!
SCT

Child's Full Name: ______________________________

☐ **I DO NOT** want my statement sent via email and would like it mailed.

☐ Please send my next statement to the following address:

____

____

Signature: ______________________________ Date: ______________