sammamish
children's therapy

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 and 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

Please fill out this form if there are any other individuals or professionals you would like us to contact or share information with (e.g. school SLP, other rehabilitation professionals, primary care provider).

Patient/Child's Full Name: _____

Date of Birth: _____

Father: _____

Mother: _____

Phone: _____ Alternative Phone: _____

I authorize mutual 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:_____

Email:_____

Permission to fax: Yes_____ No_____

Permission to email: Yes_____ No_____

Signature:_____

Date:_____

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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

48 hour notice is required if you need to cancel or reschedule your appointment. Missed appointments without 48 hour notification will be charged a $75 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 about 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 the 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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Our Notice of Privacy Practices (HIPPA) document is available at the front desk.

I have received a copy of the Notice of Privacy Practices (HIPPA) for:

Sammamish Children's Therapy

Offices in Issaquah

Client Signature:_____

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Cancellation Policy

48 hour notice is required for therapy cancellations to avoid a $75 fee to cover the therapist's time. Illness and emergencies **stated at the time of cancellation** are excluded from this fee.

We understand that cancellations are sometimes unavoidable, but we have to be mindful of our clients that are on our wait list. Because of this, there is a limit of **five cancellations**, regardless of when notification is given. Holidays are excluded from this.

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 Contact

Full Name: _____

Cell Phone Number: _____

I give permission for emergency medical treatment in my absence

Signature: _____

Patient's Doctor Information

Doctor's Name: _____

Doctor's Phone Number: _____

Patient Information

Allergies: _____

_____

Medical Conditions: _____

_____