The Lotus Tree
Sensory Integration Center
3169 South Bown Way
Boise, Idaho 83706
p) 208-433-9152
f) 208-344-4752
www.lotustreeboise.com

Patient Information

Today's Date: ____/____/____

Patient's Full Name _____ Date of Birth ____/____/____ F ☐ M ☐

Street address _____ Home phone _____

City _____ State _____ Zip _____ Email _____

Primary Care Physician _____ Phone _____

Diagnosis/Condition that you are seeking help for? _____

Are you receiving other therapies for the same condition? Yes ☐ No ☐ Please specify: _____

Insurance (Not applicable for some manual therapy services. Credit cards, cash and HSA cards are accepted at time of service)

Insurance Provider _____

Subscriber # _____ Group # _____

Subscriber Name _____ Relationship to Patient _____

Subscriber Date of Birth ____/____/____ Place of Employment _____

Current Health (*Please use back of page if additional space is needed)*

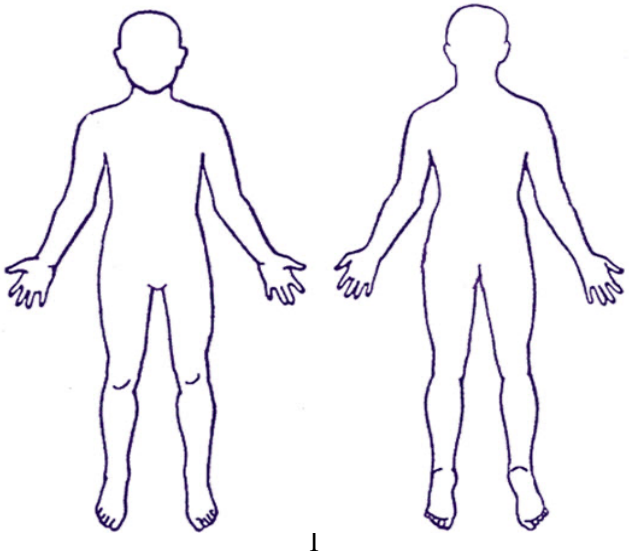
Current Medications: _____

Allergies: _____

Prior injuries/surgeries (w/approximate dates): _____

Please list and indicate on the front and back figure below any areas of pain or dysfunction: _____

Front Back



The Lotus Tree Sensory Integration Center Policies and Procedures

Please initial each line and sign below. Thank you.

____ I, _____ consent to receive treatment at The Lotus Tree Sensory Integration Center/The Lotus Tree Speech and Language Center.

____ Information provided on the Patient Information form is correct to the best of my knowledge. I grant The Lotus Tree Sensory Integration Center/The Lotus Tree Speech and Language Center the right to release my medical information and treatment history to third party payers and/or other healthcare professionals as needed.

____ I and/or the responsible party agree to assign The Lotus Tree Sensory Integration Center and its independent contracting providers the right to pursue their respective claims for reimbursement from any insurance policy or policies providing coverage for services provided.

____ I understand that if my insurance provider requires a referral for treatment, it is my responsibility to obtain the referral prior to my first appointment. I also understand that if I do not have prior written referral from my physician, I am fully financially responsible for any unpaid balances of current or past appointments. Further, I agree that I am responsible for payment for any visits beyond that of my insurance coverage.

____ I authorize The Lotus Tree to submit claims on my behalf to my health insurance agency. I authorize my insurance company to make payments directly to The Lotus Tree for services rendered.

____ I understand that my bill is to be paid within 30 days of the invoice date unless otherwise arranged with The Lotus Tree billing department. I understand that after 30 days a late fee of 1.5% monthly will be added to my account. I understand that there is a $35.00 fee for each check returned unpaid. In the event of default of payment I agree to pay fees accrued on my balance due, as well as collection costs and/or legal fees incurred for collection of my account.

____ The Lotus Tree requires 24 hours notice in the event of a cancellation. The Lotus Tree recognizes that in an unforeseen circumstance an absence without notification can occur. However if a second absence should occur, a $25.00 fee may be charged to your account. A third absence of appointment will result in possible termination of services at The Lotus Tree.

Release of Liability

____ I am fully aware of the risk of accident or injury, as well as other damages and losses associated with the participation in activities and programs at The Lotus Tree Sensory Integration Center and release The Lotus Tree from associated liability. I hereby waive and release the owner, staff members, and/or therapists employed by The Lotus Tree of liability for personal injury or accident of any sort suffered by the participant named, by reason of participation in classes, treatment or any other various activities at The Lotus Tree. I hereby agree to release The Lotus Tree of any liability for litigation expenses, attorney fees or loss liability that may occur as the result of any such claim.

____ In the event I require emergency care, I hereby authorize any associate of The Lotus Tree Sensory Integration Center/The Lotus Tree Speech and Language Center to obtain medical care and treatment without further authorization.

Name (Please Print) _____ Signature _____ Date _____

In the event of an emergency, please contact: _____ Phone: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

PLEASE CHECK ONE

I acknowledge that I have read your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information

I waive my right to read your *Notice of Privacy Practices.*

I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.* Furthermore, I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient (If patient not signing): _____

Signature: _____ Date: _____

Office Use:

Diagnosis: _____/_____

Plan Effective Date: ____/____/____ thru ____/____/____ Co-pay: $_____

Deductible: Individual $_____ Family $_____ Met yet this year? o Yes o No

% of coverage after deductible is met _____ Amount met so far : _____

Maximum benefit allowance for: ___ OT ___ PT ___ ST

Number of visits allotted per year: _____ AND/OR Max amount for therapy per year: $_____