THE THERAPY CENTER
Solutions for peace of mind.

7807 E Funston
Wichita, Ks 67207
316-636-1188
www.therapycenterwichita.com

Patient Information Date:_____

Name:_____ DOB:_____ SSN:_____

Address:_____ City:_____ State: _____ Zip:_____

Home phone:_____ Work phone:_____ Cell phone:_____ Primary Care Dr.:_____

Email Address:_____

Mother's/Spouse Name:_____ Father's Name_____

Race:_____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Declined Language Spoken at home:_____

Primary Insurance Information (person who carries the insurance)

Name of Insured:_____ DOB:_____ SSN: _____

Driver's License #_____

Address:_____ City:_____ State: _____ Zip:_____

Home phone:_____ Work phone:_____ Cell phone:_____

Insurance Company_____ Relationship to patient:_____

Employer: _____ Grp #_____ ID#_____

Financially Responsible Party/PERSON SIGNING PAPERWORK (Person to receive statements, consents to treatment)

Name:_____ DOB:_____ SSN:_____

Driver's License #_____

Address:_____ City:_____ State: _____ Zip:_____

Home phone:_____ Work phone:_____ Cell phone:_____

Relationship to patient:_____ Employer: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING

Secondary Insurance Information

Name of Insured:_____ DOB: _____ SSN: _____

Home phone:_____ Work phone:_____ Cell phone:_____

Relationship to patient: _____ Employer:_____

Insurance Company:_____

Grp #_____ ID#_____

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Financial Policy
Please Read Before Signing
Effective **1/1/2014**

The patient/guarantor is responsible for providing The Therapy Center with current, active insurance information. A copy of the insurance card will be scanned into your chart. If your insurance changes, please notify our office immediately.

Your insurance coverage is a contract between you and your insurance carrier. You remain responsible for any portion of your bill that is not paid by your insurance carrier regardless of the reason for the carrier's non-payment. If you do not have a secondary insurance carrier to cover any co-payments or deductibles, you are responsible for payment of such amounts. All insurance companies require co-payments be made at the time of service.

Insurance co-payments are due at check-in, prior to seeing the provider. The Therapy Center will submit claims to your primary and secondary insurance as indicated. Once the insurance has processed, an account statement will be mailed to the guarantor of the account for any non-covered services, deductibles, or co-insurance.

The responsible party, named below and/or the patient agrees to pay our costs for collection amount owing, including court cost, attorneys' fees, and collection cost. The cost of collection will not include costs that were incurred by a salaried employee of ours, will not include recovery of both attorneys' fee and collection agency fees, and will not be in excess of fifteen percent (15%) of the unpaid debt after default.

In certain circumstances, The Therapy Center may contact your insurance in advance to inquire about coverage for special procedures or tests. If it is determined that the service is not covered or will be applied to your deductible, we may require payment in advance.

The Therapy Center accepts personal checks (payable to your provider), Visa, MasterCard and Discover credit cards.

I have read and understand the Financial Policy of The Therapy Center.

_____ _____

Patient Name | Date of Birth

_____ _____

Patient/Guarantor Signature | Date

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Patient Missed Appointment Policy

Staff and clinicians work hard to provide you, our patients, with excellence of service with the utmost professionalism. Our commitment to your well-being is taken seriously by everyone here at The Therapy Center. Our time, as is yours, is very important to us. Missed appointments are missed opportunities for both the patient and the therapist.

With the exception of serious emergencies it is expected that you keep all of your appointments. If you need to re-schedule an appointment we require a 24 hour notice. In such a case, please call our office and arrange to reschedule that appointment with our Front Desk Receptionist.

In an instance of a cancellation without a 24 hour notice or no-show to a scheduled appointment, we reserve the right to charge you a cancellation fee. If you are consistently missing your scheduled visits, we also reserve the right to discontinue care.

We appreciate you greatly as our patient and strive to accomplish positive results and success for you.

_____ _____

Patient Name Date

_____

Patient/Guarantor Signature

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Acknowledgement of Receipt of Notice of Privacy Practices

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of your Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign.

Due to an emergency situation it was not possible to obtain an acknowledgement.

We weren't able to communicate with the patient.

Other (Please provide specific details)

_____
_____
_____
_____
_____
_____

_____ _____

Employee signature Date

HIPPA Acknowledgment of Receipt of the Notice of Privacy Practices.
This form does not constitute legal advice and covers only federal not state law.