LIBRE THERAPY SERVICES, LLC
311 NE 8th ST Suite 104 Homestead, FL 33030
TEL: (305) 248-8600 / FAX: (844) 272-8151

ENROLLMENT INFORMATION FORM

Patient Name: _____ Name of Parent(s) or Guardian(s): _____

Date of Birth: _____ Sex: M / F Date of Birth: _____

***Please provide copy of insurance card & Driver's License**

Primary phone (H / C / W): _____

Secondary phone (H / C / W): _____

E-mail: _____

Address: _____ City: _____ State: ____ Zip code: _____ Apt: _____

Referring Physician: _____

Phone: _____ Fax: _____

Primary Physician: _____

Phone: _____ Fax: _____

Insurance Name: _____ ID #: _____

SSN: _____ Group #: _____

Policy Holder's Name: _____

Relationship to Patient: _____ Date of Birth: _____

Secondary Insurance: _____

I understand that the services provided are not free and I accept the responsibility for payment of all or any portion of charges not authorized nor covered by my insurance provider.
I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf (above named).

_____ _____
Patient/Parent/Legal Guardian Signature *Date*

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for ***LIBRE THERAPY SERVICES, INC.*** to furnish medical care and treatment to (patient –printed name) _____considered necessary and proper in diagnosing or treating his/her physical and medical condition.

Patient/Guardian/Responsible Party _____Date_____

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BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third-party payers to ***LIBRE THERAPY SERVICES, INC.*** A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Patient/Guardian/Responsible Party _____Date_____

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full of you. If your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customer fee schedule, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to ***LIBRE THERAPY SERVICES, INC.*** The above may not apply for those patients that are considered Worker's Compensation or who have benefits with a balance billing contract, such as an HMO.

LIBRE THERAPY SERVICES, INC. **verifies benefits as a courtesy to you. However,** ***LIBRE THERAPY SERVICES, INC.*** **does not accept responsibility for any incorrect information given by your insurance carrier regarding your copay/co-insurance benefits or benefit plans.**

When you pay by check, you expressly authorize ***LIBRE THERAPY SERVICES, INC.***, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit (plus any applicable sales tax). Please note: the above language authorizes an electronic debit to your account for the state allowed recovery fee. In accordance with the rules of the National Automated Clearing House Association, you may call (888) 235- 4635 to revoke the authorization for the electronic transaction. This does not, however, mean that ***LIBRE THERAPY SERVICES, INC.*** cannot collect a returned check fee by other methods.

I understand and agree that if my account is sent to our Collection Agency for payment that I will be assessed an additional charge that would increase my total bill by 34%. I further understand that I will also be responsible for any necessary attorney fees and legal costs.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT

_____ _____

Patient/Parent/Legal Guardian Signature Date

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KEEPING YOUR APPOINTMENTS AT LIBRE THERAPY SERVICES

We are here to help you achieve your goals and return to work and to the life that you want. We will do our part to the best of our ability to help you improve. You will get the most out of your time in therapy by fully participating in your treatment… that means attending your appointments and doing your home exercises.

We do understand things can happen that may be out of your control that could interfere with your appointment times such as illness or emergency. In the event this happens, please contact us so that we are able to make your appointment time available to another client.

Upon cancellation without 24 hour notice, a $25 fee will be charged to you (not your insurance company) and will be collected prior to the subsequent visit. Please note that if multiple appointments are cancelled without notice, you may be discharged at the discretion of our staff.

For clients who are being treated for a work-related injury under Workers' Compensation, please note:

- If you cancel your appointment without rescheduling or fail to attend a scheduled appointment without notifying our office, resulting in fewer weekly visits than assigned by your physician, please be aware that your doctor, employer, and nurse case manager or adjuster will be notified.

We look forward to working with you to reach your goals and appreciate your cooperation.

_____ _____

Patient/Parent/Guardian Signature Date

_____

Patient/Parent/Guardian Name

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NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting RAQUEL RODRIGUEZ, Privacy Officer.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Patient/Parent/Guardian Signature Date

_____

Patient/Parent/Guardian Name

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Name: _____ Date: _____

At LIBRE THERAPY SERVICES, our goal is to provide you with the most complete, personalized care. In order to do so, we ask that you fill out this medical history questionnaire.

List any allergies: _____

Was there anything unusual about the pregnancy or birth? ___Yes ___No
If Yes please describe_____

Medications, Vitamins, Supplements	Method (circle one)	Dosage	Frequency (circle one)
	Oral Patch Inhaler Injection		1x/day 2x/day 3x/day
	Oral Patch Inhaler Injection		1x/day 2x/day 3x/day
	Oral Patch Inhaler Injection		1x/day 2x/day 3x/day

Did the child go home with his/her mother from the hospital? ____Yes ____No

If child stayed at the hospital, please describe why and how long _____

_____

Has your child received any other evaluation or therapy (Physical therapy, counseling, occupational therapy, vision, etc.)?

__Yes __No If Yes, please describe_____

_____

Special Diet: Yes__ No__ If yes, please describe_____

Seizures: Yes__ No__

Equipment used at home: _____

List any surgeries:_____

Medical History

Has your child had any of the following?

__Adenoidectomy
__Allergies
__Breathing difficulties
__Chicken Pox
__Colds
__Ear infections (How often? ____)
__Ear tubes
__Encephalitis
__Flu
__Head Injury
__High Fever
__Measles
__Meningitis
__Scarlet Fever
__Seizures
__Sinusitis
__Sleeping Difficulties
__Thumb/Finger sucking habit
__Tonsillectomy
__Tonsillitis
__Vision Problems

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Other serious injury/surgery? _____

Behavioral Characteristics:

__ Cooperative

__Attentive

__Willing to try new activities

__Plays alone for reasonable length of time

__Separation difficulties

__Easily frustrated/Impulsive

__Stubborn

__Restless

__Poor eye contact

__Easily distracted/short attention

__Destructive/aggressive

__Withdrawn

__Inappropriate behavior

__Self-abusive behavior

If your child is in school, please put Name of school and grade your child is currently in: _____

_____