Southland Therapy Services, Inc.

1094 A Eisenhower Drive Savannah, Ga. 31406
(912) 335-1650

Patient Information and Therapy Authorization

Patient Name:_____ Date of Birth_____ Age_____
Address:_____ Referring Physician:_____ Phone#_____
_____ Patient's Social Security #_____
Phone: (home)_____ (work)_____ (cell)_____ (other)_____
Caregivers Name (and relationship)_____

Email address _____

Does patient have an IEP(Individual Education Plan) or IFSP(Individual Family Service Plan)? YES or NO, circle one

Primary Insurance Coverage Information
Payor:_____ Plan_____ Policy#_____ Group#_____
Claims address:_____ Phone:_____
Policy Holder Information:
Full Name:_____ Relationship to patient:_____ DOB:_____
Employer:_____ Gender:_____
Address and Phone # (if different than Patient)_____

Secondary Insurance Coverage Information
Payor:_____ Plan_____ Policy#_____ Group#_____
Claims address:_____ Phone:_____
Policy Holder Information:
Full Name:_____ Relationship to patient:_____ DOB:_____
Employer:_____ Gender:_____
Address and Phone # (if different than Patient)_____

Patient Financial Responsibility (please initial each):

_____ I understand that I have been referred for therapy services and care with Southland Therapy Services. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have Southland Therapy Services provide treatment and care as prescribed by my physician and/or recommended by my therapist.

_____ I hereby authorize Southland Therapy Services to furnish my insurance company(s) any information that may be required in order to determine benefits and process claims. I authorize payment of medical benefits to Southland Therapy Services for services rendered to me. I certify by my initials that I have read the above and agree to this policy.

_____ **Any services rendered are charged to the patient and due at the time of service.** As a courtesy Southland Therapy will file your claim with your insurance carrier, however the patient or responsible party is ultimately responsible for the charges not covered by your insurance. Any copayments or deductible amounts not satisfied with your carrier are due at the time of service. It is the patient's responsibility to understand their insurance coverage.

_____ Statements from Southland Therapy Services are due upon receipt. If a discrepancy exist with your balance due, please contact Southland Therapy otherwise your payment is expected upon receipt. Unpaid balances can ultimately result in accelerated collection practices.

_____ I acknowledge that I am financially responsible to Southland Therapy for any balance not covered under my plan from my insurance carrier.

Patient Name:_____

Patient / Authorized Representative signature:_____ Date_____