Therapy Center of Acadiana

FOR INDIVIDUALS WITH DEVELOPMENTAL DELAYS

Welcome!

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Therapy Center of Acadiana, LLC, 300 Park West Drive, Scott, LA 70583
Mail to: P.O. Box 331, Scott, LA 70583-0331
Email to: ABA@tcacadiana.com
Ph: 337-233-1167 Fax: 337-233-1168

Therapy Center of Acadiana

FOR INDIVIDUALS WITH DEVELOPMENTAL DELAYS

Dear parents and guardians,

I'd like to wish you a warm welcome to the TCA family!

We have been here, doing what we love, for over 10 years. We strive to be the best for your kids and are lucky to have seen many amazing results along the way. Our promise is to always put your child first! We exemplify this by providing high-quality ABA Therapy with a focus on offering effective, compassionate, and client-focused care. We understand that every child is unique and we tailor our programs to highlight their strengths and to bring out the very best in them. We are so glad to have you here and can't wait to get to know you and to watch your child thrive! Thanks for choosing TCA. We won't let you down!

Jenny Jordan

Chief Operating Officer

Information Request

In order for us to process authorization for ABA services with your insurance company, TCA will need the following:

1) Assessment Report from the doctor who diagnosed your child with their presenting disorder (Autism, ADHD, etc). This document is usually several pages in length and includes the name and results of the assessment(s) used to diagnose the disorder. For your knowledge, the most common types of assessment for an Autism diagnosis are the ADOS-2 and the Vineland-II. ****Can be faxed directly from diagnosing physician to TCA at 337-233-1168 or emailed to ABA@tcacadiana.com****

2) Referral letter and/or Prescription for ABA services from either your child's diagnosing physician or current primary care physician (usually from diagnosing physician). This letter must be on your doctor's letterhead and include the doctor's signature. The letter should be dated within the last 90 days and include the patient's name, date of birth, diagnosis, and the wording "refer to Therapy Center of Acadiana for ABA Therapy". ****Can be faxed directly from referring physician to TCA at 337-233-1168 or emailed to ABA@tcacadiana.com****

3) Authorization to Release or Obtain Healthcare Information form provided by TCA. Please fill out this form using the **diagnosing physician's** information. This allows TCA to contact the patient's diagnosing physician in order to obtain any supplemental medical information that may be needed throughout the insurance authorization process as well throughout the course of therapy.

4) "Welcome Packet" paperwork provided by TCA.

5) Copies or pictures of Parent(s) or Guardian(s) driver's licenses and insurance cards (front and back).

If there is anything we can do to assist you in this process, please do not hesitate to call our office at 337-233-1167 or email us at ABA@tcacadiana.com. We would be happy to help you!

Therapy Center of Acadiana, LLC, 300 Park West Drive, Scott, LA 70583
ABA@tcacadiana.com
Ph: 337-233-1167 Fax: 337-233-1168

Patient/Member:_____

Admission Form

Patient Demographic and Relevant Medical Information:

First Name:	Middle:	Last Name:	DOB:
Nickname:	Age:	Sex:	SSN:
Physical Address:			
City:	State:	Zip Code:	If patient mailing address differs from physical address, please report additional information.
Diagnosis:		Diagnosis Date:	
Diagnosing Physician:			
Diagnosing Physician Practice Name:			
Primary Care Physician (PCP):		PCP Start Date of Care:	
Primary Care Physician Practice Name:			
Referring Physician:			
Date of Referral:			
Medication Allergies:			
Food or Environmental Allergies:			

Primary Billing Information (Please submit a copy of front and back of all insurance cards):

Person responsible for payment:	
Insurance Provider:	Policy Number:
Name of Policy Holder:	Relationship to Patient:
Policy Holder's Social Security Number:	
Policy Holder's Employer:	

Secondary Billing Information (if applicable):

Person responsible for payment:	
Insurance Provider:	Policy Number:
Name of Policy Holder:	Relationship to Patient:
Policy Holder's Social Security Number:	
Policy Holder's Employer:	

Parental Demographic Information:

Father's Last Name:		First:	Middle Initial:
Title: Dr. Mr.	Name Suffix:	Age:	Is this individual the biological father of the patient?
Social Security Number:		Date of Birth:	
Sign attesting you are legal guardian for patient:			
Does this individual reside with patient:	Yes – Full Time ☐	Yes – Part Time ☐	No ☐ Other ☐
Physical Address:		Martial/Legal Status:	
City:	State:	Zip Code:	If mailing address differs from physical address, please report additional information.
Cell Phone:		Alternative Phone:	
Email Address:			
Mother's Last Name:		First:	Middle Initial:
Title: Dr ☐ Ms ☐ Mrs. ☐	Name Suffix:	Age:	Is this individual the biological mother of the patient? Yes ☐ No ☐
Social Security Number:		Date of Birth:	
Sign attesting you are legal guardian for patient:			
Does this individual reside with patient:	Yes – Full Time ☐	Yes – Part Time ☐	No ☐ Other ☐
Physical Address:		Martial/Legal Status:	
City:	State:	Zip Code:	If mailing address differs from physical address, please report additional information.
Cell Phone:		Alternative Phone:	
Email Address:			

Patient Education Information:

School Name:							
School Address:							
City:		State:		Zip Code:		Grade Level:	

Does the patient have an active IEP:	If patient has an IEP, please provide a copy prior to consultation.
Percent of Time in Mainstream Classroom:	Percent of Time in Resource Classroom:
Name of School Personnel:	Position (i.e. Teacher, Principal, Speech Therapist):

You may supplement this list and attach it to this packet as needed.

Treatment Information (Privatized treatments only. No treatments provided through the school system):

Name of Speech Therapist:				
Name of Speech Therapist Practice:				
Physical Address:				
City:	State:	Zip Code:		If mailing address differs from physical address, please report additional information.
Phone Number:	Email Address:			
Frequency of Treatment:	Treatment Start Date:			
Response to Treatment:				
Name of Occupational Therapist:				
Name of Occupational Therapist Practice:				
Physical Address:				
City:	State:	Zip Code:		If mailing address differs from physical address, please report additional information.
Phone Number:	Email Address:			
Frequency of Treatment:	Treatment Start Date:			
Response to Treatment:				

You may supplement this list and attach it to this packet as needed.

Contact Permission:

Form of Contact	May be contact you using this information?	May we leave a detailed message?	May we leave a non-detailed message?	Please rank the order in which we you would like to contact you (Please more a "1" for the first point of contact)
Patient Address	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Father's Address	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Father's Cell Phone	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Father's Alt. Phone	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Father's Email	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Mother's Address	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Mother's Cell Phone	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Mother's Alt. Phone	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Mother's Email	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	

Patient/Member:_____

Disclaimer and Signature:

Disclaimers: Therapy Center Acadiana does not discriminate on the basis of disability type or level, sex, race, creed, sexuality, nationality, gender identity, or ethnic background. Therapy Center of Acadiana holds the right to release any patient at any time due to clinical reasoning such as extreme situations that may endanger the health or safety of patients, staff, or others. It is the responsibility of the patient's legal guardians to ensure all information provided to Therapy Center of Acadiana remains updated to ensure accurate treatment. All relevant information that concerns treatment should be fully disclosed in writing and failure to disclose important information about patient behavior, medical conditions, treatment needs, or medical history shall absolve Therapy Center of Acadiana and its staff of any liability associated with unreported information. All information must be present along with supporting documents prior to receiving treatment. Your signature below attests to the fact that the provided information is accurate and up-to-date and that you agree with all of the aforementioned terms and conditions. The patient's legal guardian, signing below, gives Therapy Center of Acadiana the right to disclose your Protected Health Information with your payer source solely for the purposes of securing payments for our services. That patient's legal guardian, signing below, gives Therapy Center of Acadiana the right to disclose your Protected Health Information with your Primary Care Physician, Diagnosing Physician, Referring Physician, or any other professional entrusted with managing your medical and behavioral health services.

_____ _____

Signature of Legal Guardian Date of Signature

_____

Printed Name of Legal Guardian

Patient/Member:_____

300 Park West Drive, Scott, LA 70583
Phone: 337.233.1167
Fax: 337.233.1168

AUTHORIZATION TO RELEASE OR OBTAIN HEALTHCARE INFORMATION (INCLUDING WRITEN, ORAL, AND ELECTRONIC INFORMATION)

Patient's Name:
Patient's Date of Birth:
Address:
Requestor: Relationship: Date:

I authorize:

Name: **Therapy Center of Acadiana, LLC**
Address: **300 Park West Drive, Scott, LA 70583**
Contact Information: **337-233-1167 or fax 337-233-1168**
Relationship to Patient: **Applied Behavior Analysis Provider**

☐ To RELEASE Information TO or ☐ To OBTAIN Information FROM

Name (Physician and/or Group):
Address:
Contact Information:
Relationship to Patient:

Please release the following information:

☐ Assessment Summary Report	☐ Behavior Intervention Plan	☐ Treatment Progress
☐ History of Treatment	☐ Problem Behavior Intervention	☐ Functional Analysis Results
☐ Clinical Suggestions	☐ Discharge Summary	☐ ALL CLINICAL RECORDS
☐ Referral for ABA		

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to an authorized member of the provider's staff. I understand that the authorization will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

If I fail to specify an expiration date, event, or condition, this authorization will expire in twelve (12) months from the date of authorization. An authorization is voluntary. I will not be required to sign an authorization as a condition of receiving treatment services or payment, enrollment, or eligibility for health care services. Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected under the Health Insurance Portability and Accountable Act of 1996. I understand that my child's evaluation and treatment is not conditioned on the signing of this authorization.

____

X _____ Date:

Patient/Guardian

Patient/Member:_____

Notice of Privacy Policy

PLEASE READ CAREFULLY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or verbally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse Protected Health Information (PHI).

Uses and Disclosures of Protected Health Information: Your Protected Health Information may be used and disclosed by your BCBA, your therapist, and/or our office staff for the purpose of providing quality health care services to you, to pay your health care bills, to support operation of the therapy practice and any other use required by law.

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent: Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law.

Release of patient information pursuant to 45 CFR 164.508: By signing this document, you authorize and request the disclosure of all protected health information for the purposes of review and evaluation in connection with a legal claim. By signing this document, you expressly request that the designated record custodian of all covered entities under HIPAA identified as Therapy Center of Acadiana, LLC, located at 300 Park West Dr. Scott, LA 70583, disclose full and complete protected medical information including all medical records, meaning every page on record, including but not limited to: office notes, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers. All records from consultations and/or evaluations, test scores, and as progress notes. All disability, Medicaid or Medicare records including claim forms, if applicable. All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the entire period from consultation, start of treatment to last therapy session.

Privacy Policy Acknowledgement

I acknowledge that I have read and agree to the attached Privacy Policy provided to me by the Therapy Center of Acadiana.

Patient's Name: _____

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Staff Member Signature Date

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