



Therapeutic Specialties of NC, PLLC

104 Market St, Henderson, NC 27537
Ph. 252-431-4418 Fax 252-572-2418



Emergency Contact Information Form

This information will be extremely important in the event of an accident or medical emergency.

Please be sure to sign and date this form

Client Name: _____

Home Phone: _____ Cell Phone: _____

Home Email Address: _____

Address: _____
Street City State Zip Code

Primary Emergency Contact Name: _____

Relationship: _____

Phone: Home: _____ Cell: _____ Work: _____

Secondary Emergency Contact Name: _____

Relationship: _____

Phone: Home: _____ Cell: _____ Work: _____

Preferred Local Hospital: _____

Insurance Company: _____

Insurance Policy #: _____

Comments: include any special medical or personal information you would want an emergency care provider to know – or special contact information:

I, _____, give permission for Therapeutic Specialties of NC to seek emergency care from a hospital or physician in the case of an emergency.

Client Printed Name Date

Client Parent/Guardian Printed Name Date

Signature of Client or Parent/Guardian Date

NOTE: You may request a copy of this agreement for your review.



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Attendance Policy

Speech Therapy

The following policies are guidelines regarding absences, assuming an 80% or above overall attendance rate:

Ex. 80% at 2x weekly = 6 / If you have 8 appointments a month 6 must be attended monthly

80% at 1x weekly = 3 / If you have 4 appointments a month 3 must be attended monthly

Missed Appointments, Makeup Policy, & Late Arrival To ensure consistent progress, regular attendance is required. When an appointment is missed, it impacts not only therapy progress but also prevents other potential clients from accessing services. Clients with 3 late cancellations (<24 hours) and/or no-shows in a 3-month period may lose their regular weekly appointment slot and be discharged from services. The client may be added to the bottom of the waitlist for potential re-entry. All missed appointments may be made up if the therapist has time in her schedule. **At least 50% of missed appointments are expected to be made up within 30 days of the missed appointment.** A make-up appointment does not erase a no-show from the record. In addition, If you arrive late for your appointment, clinicians will only be able to see you for the remainder of your scheduled appointment as therapists tend to have appointments back-to-back.

Counseling/Evaluations/Speech

No Show Policy & Walk-In Status Process: If you miss 3 scheduled appointments (no show) without cancelling in advance in a 3-month period, you will no longer be able to schedule an appointment. An appointment will be counted as “no show” if you do not call to cancel a scheduled appointment. At that time, you may be placed on “Walk-In” status. On “walk-in” status, you may call the office at the beginning of the day to see if your therapist is in and ask to be seen as a “walk-in.” You may be seen if your provider has a cancellation during the day, but there is no guarantee that you will be seen that day. After you “walk-in” for three appointments you may be added back to the schedule if there is an opening, otherwise you will be added to the bottom of the waitlist. For *speech clients* this applies so long as there is an active authorization on file, as required by some insurance companies.

Please note, reminder texts/calls for appointments are a courtesy! It is expected that you keep up with all appointments. If you do not receive an appointment reminder via text/call that is not a justified reason to miss an appointment and will be considered a “no-show.”

Counseling Appointments

Recurring Appointments: For clients who are scheduled on a recurring basis, it is **your responsibility** to keep track of when those appointments are coming close to an end. When you see that you only have a few appointments left, please make sure that you notify the office assistant so that she can schedule more appointments for you. If you run out of appointments, you may have to wait a few weeks to get back on the schedule.

Counseling/Evaluation Appointments

Pick-up Times: If you choose not to stay on clinic premises during a minor’s appointment, please arrive at least 15 minutes before the anticipated end of the appointment. If there are 2 or more late pick-up times in a 30-day period, the caregiver will be required to remain on site during the minor’s treatment. If you are not here at the time the appointment ends the provider cannot sit with the minor as the provider has additional appointments and/or other responsibilities.

Client Printed Name

Parent/Guardian Printed Name (if applicable)

Client if adult/Parent/Guardian Signature

Date



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PLEASE READ CAREFULLY AND COMPLETE

- ____ *Initial* I have read the Therapeutic Services Agreement, understand, and agree to the policies described.
- ____ *Initial* I understand TSofNC Policies and Procedures Manual, including the TSofNC Cultural Competency Plan. I also understand I can receive a copy at any time by request.
- ____ *Initial* I agree to the no show policy.
- ____ *Initial* I agree to keep track of my or my child's appointments and understand it is my responsibility to make all appointments.
- ____ *Initial* I understand and agree to the confidentiality policy.
- ____ *Initial* I understand that copays are due at the time of service, and it is my responsibility to understand my child's or my insurance policy, including deductibles, co-insurance, and/or copays.
- ____ *Initial* I understand that final payment on behalf of the client is expected before reports or summaries (including psychological evaluations) are released.
- ____ *Initial* I understand that if my account is turned over to collections or small claims court, I am responsible for interest and fees charged for time spent filing claims or attending court and any additional fees incurred by TSofNC in pursuit of payment for services rendered.
- ____ *Initial* I acknowledge the opportunity to review the HIPAA Notice of Privacy Practices. I understand that if requested, I may have a copy of all policies.

Your signature below indicates that you have read this contract and agree to its terms and serves as an acknowledgement that you have been offered the HIPAA Notice of Privacy Practices. Your signature also serves as confirmation that you have read and understand your or your child's rights as a client.

Client Printed Name

Date

Parent/Guardian Printed Name

Date

Signature of Client or Parent/Guardian

Date

NOTE: You may request a copy of this agreement for your review.



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Authorization to Disclose Health Information

Client Name: _____ Date of Birth: _____

I hereby authorize TSofNC and the following parties to communicate with and disclose specific health information to one another from the records of the client.

- ☐ Franklin County Schools 53 West River Road Louisburg, NC 27549 (919-496-2600)
- ☐ Granville County Schools 101 Delacroix Street Oxford, NC 27565-4613 (919-693-4613)
- ☐ Halifax County Schools 9525 Highway 301 S Halifax, NC 27839 (252-583-5111)
- ☐ Vance County Schools 1724 Graham Avenue Henderson, NC 27536 (252-492-2127)
- ☐ Warren County Schools 109 Cousin Lucy's Lane Warrenton, NC 27589 (252-257-3184)
- ☐ Other: _____

Name of Current or Most Recent School & Teacher: _____

Specific information to be disclosed - Please select the information you authorize to be released:

☐ Entire Record

Only the following:

☐ Assessment/Evaluation

☐ Referral Information

☐ Treatment Plan Information

☐ Demographic Information

☐ Progress Notes

☐ Rating Scale Forms

☐ Discharge Summary

☐ Other: _____

If my record contains information related to HIV, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, or genetic testing, this disclosure will include that information for the explicit purpose above.

☐ Yes, I understand

☐ I do not want this information disclosed Initial: _____

Client Rights - I understand that:

- I may request a copy of this signed authorization.
- Any action taken in reliance on this authorization prior to the revocation date is legal and binding.
- My information may not be protected from re-disclosure by the requester; however, if this information is protected by the Confidentiality of Substance Use Disorder Patient Records Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided by state or federal law.
- I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits.
- I may revoke this authorization at any time and will be asked to sign the Revocation Section on the back of this form.

This authorization shall remain in effect for **one year from date of signature**.

Printed name of Client

Date

Witness (required when signature is X, mark or symbol)

Printed name of Parent/Guardian

Date

Signature of Client/Parent/Guardian

Date

Personal Representative Relationship/Authority



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Health and Wellness Policy

Attendance Health Guidelines

To help keep all children, families, and providers healthy, please follow these attendance guidelines:

- **Fever:** Do not bring your child for therapy if he/she has had a fever within **24 hours** of their scheduled session. This includes low-grade fevers (generally defined as **100.0°F / 37.8°C or higher**).
- **Illness Symptoms:** Please keep your child home if he/she is experiencing any signs of illness, including but not limited to:
 - Persistent cough
 - Runny or congested nose
 - Sore throat
 - Vomiting or diarrhea
 - Suspected cold, flu, or other contagious conditions
- **Early Week Symptoms / Courtesy Notice:** If your child begins showing symptoms earlier in the week that may impact their ability to attend their scheduled session, please notify your provider as soon as possible. This helps us plan accordingly and may prevent a **late cancellation** if symptoms persist the morning of the appointment.

Speech Therapy Only

- **Make-up Sessions & Attendance Expectations:** To maintain your or your child's regular appointment time, clients are expected to complete make-up sessions for missed visits (including those related to illness) at a rate of **50% or higher**. Consistent attendance and participation in make-up appointments helps ensure continuity of care and progress in therapy. Repeated missed sessions without make-up participation may result in discharge from treatment.

Thank you for helping us maintain a safe and healthy environment for everyone!

Client Printed Name

Parent/Guardian Printed Name (if applicable)

Client if adult/Parent/Guardian Signature

Date



Leave blank if there are no medications.

Medication Log

Client: _____ **DOB:** _____

ID #: _____ **Date:** _____

[illegible]