A TEAM APPROACH
PEDIATRIC THERAPY CENTER
OCCUPATIONAL THERAPY · PHYSICAL THERAPY · SPEECH PATHOLOGY

We appreciate the opportunity to work with you and your child. Please read through and complete all paperwork before your arrival. We ask that you please arrive 15 minutes prior the start of your appointment. After completion of this packet, please sign below and return to Pediatric Therapy Center at the time of your evaluation. Thank you for your confidence in Pediatric Therapy Center and we look forward to working with you and your family.

Client Information

Date_____

Client's Name:_____ Date of Birth: _____/____/_____

Address:_____
_____

Parent/Guardian Information

Parent Name/Guardian:_____ (relation) _____

Cell Phone :_____Home Phone: _____Work:_____

Employer:_____ DOB:_____

E-Mail Address:_____

Address (if different than client's) _____

Parent Name/Guardian:_____ (relation)_____

Cell Phone :_____Home Phone: _____Work:_____

Employer:_____ DOB:_____

E-Mail Address: _____

Address (if different than client's) _____

Emergency contact & Relationship: _____

INSURANCE: YES NO

Circle one: HMO PPO CCAH CASH OTHER
_____

Name of Insurance: _____

Billing Address: _____

City_____State____Zip_____

ID#_____Group#_____Deduct:$_____copay$_____

Name of Insured:_____DOB_____Relationship to client_____

Primary Care Physician: _____ Phone: _____

DO YOU HAVE A SECONDARY INSURANCE: YES NO
** We do not bill secondary insurances.

DO YOU HAVE SARC? YES NO
Case Worker name and number: _____

School Information

Name of School: _____ Current Grade:_____

Teachers Name:_____

Academic Concerns:_____

Does your child currently receive school based services? YES NO
If so, please provide types of therapy and frequency:
_____

Allergies/Food Permission/Dietary Information

Please list any allergies your child may have, including food, non-food, and/or latex:
_____
_____

Please complete the following to allow your child to participate in snack activities.
_____ My child may participate in snacks and has no diet restrictions.
_____ My child may participate in snacks if diet restrictions are observed.

Diet Restrictions:
_____ My child may participate in snacks; however, I will provide his/her snack.
_____ My child should not participate in snack time.

Video and Picture Release

_____ I give permission for my child's picture/video to be used by Pediatric Therapy Center, for the purpose of training other professionals or paraprofessionals.
_____ I give permission for my child's picture/video to be used by Pediatric Therapy Center, for marketing/publicity.
_____ I do not wish my child's picture/video to be used for any purpose other than training his/her specific clinical team.
_____ I do not give permission for any photos/video to be taken of my child

Consent to Release/Receive Medical Information:

We understand the importance of coordinating and communicating with other persons involved in your child's development. We encourage you to provide us with contact information of other professional(s) working with your child.
I agree to let Pediatric Therapy Center, to share and receive information from other agencies (organizations) about my child so services can be coordinated and optimized for my child's benefit. The following organizations are included in this release:

Medical Professionals:
_____
Schools/Teachers:
_____
Other:_____

CLIENT HISTORY

BIRTH HISTORY
Prenatal History

Please describe the pregnancy:
_____

Weight:_____ Duration of Pregnancy_____Type of Delivery_____

Any Complications at Birth? _____

Treatment Received by Baby or Mother?_____

Who lives at home with your child? (give brief description of family dynamic)
_____

MEDICAL HISTORY

Most recent hearing test: Date:_____Results:_____

Most recent vision test: Date:_____Results:_____

Number of ear infections: ____ Describe Treatment: _____

Are immunizations up to date? _____

Any medical or school diagnosis? _____

Current Medications: _____

Any other pertinent medical history: _____

Does your child use glasses, hearing aid, braces, wheelchair or any other special equipment?
_____

Does your child **have allergies**, seizures or any other medical problems we should know about?

_____

Any other therapy and/or special education programs that your child have had or is currently receiving? (including, Chiropractic, Acupuncture, Psychotherapy etc.)_____

_____

DEVELOPMENTAL MILESTONES
Please list **the age at which your child was able to accomplish** these listed below**:**

Turn head side to side: _____Sit alone:_____ Lift head while on tummy: _____

Crawl/Creep: _____Roll Over: _____Pull to stand: _____

Cruise, walk with support: _____ Walk alone_____ Climb stairs:_____

Walk down stairs:_____ Chew:_____ Drink from cup:_____

Feed self with spoon:_____ Babble: _____ Say words:_____

Speak in phrases:_____ Speak in sentences:_____

Play with children:_____

GENERAL QUESTIONS

Why are you seeking out an evaluation?

_____

_____

What does your child like?

_____

_____

What is more challenging for your child?

_____

_____

What do you enjoy doing with your child?

_____

_____

What would you like us to help you and your child do?

_____

_____

Is there anything else you would like us to know at this time that you feel can help us provide better services for your child?

_____

_____

CLIENT'S NAME:__ _____

Professional services are due and payable when rendered.

CANCELLATIONS

24-hour notice of cancellation is required for all appointments. Late cancellations are charged at 50% of fee. "No shows" are charged at 100% of fee. Please call our front office and leave changes or cancellations with our receptionist, or after hours, in our general voice mailbox available 24 hours.

Clients may be dropped off the schedule after two consecutive "no shows." When a client's attendance rate is less than 50% of the scheduled visits they may be dropped from the schedule (can be considered for a wait list).

INSURANCE POLICY

We do not bill PPO commercial carriers outside of our contractual agreements. If you have obtained a doctor's prescription for your child's therapy, you, the parent/guardian can submit a claim to your insurance company for each therapy session. Pediatric Therapy Center is committed to assisting you with this by providing you with the accurate diagnostic codes (ICD-9) and procedural codes (CPT-4) for each therapy session in order for you to submit an accurate claim. Not all insurance policies cover therapy. Payment is ultimately the responsibility of the parent/guardian requesting services. Any time private insurance is used, an initial evaluation and written report, must be the first service billed. This is regardless of any other evaluations that have been completed through other payers/vendors.

ADDITIONAL PROFESSIONAL FEES

Please realize your child's therapy program involves therapist's time and services in addition to the actual therapy session. It is often necessary for us to bill these additional services such as parent conferences, reports and preparation of

additional paperwork for medical review. It is your responsibility to review our Fee Schedule, which details these charges.

GENERAL POLICIES FOR HEALTH AND SAFETY

Pediatric Therapy Center does not discriminate based on race, religion, sex or political beliefs.
Harassment of clients, parents/guardians therapists and staff is not tolerated. Any incident is to be reported to the treating therapist or Director of Services.
In the event of an emergency requiring building evacuation, follow the procedure posted in the waiting room and hallway. You must exit the building immediately. The therapist working with your child will be responsible for escorting him/her to safety outside the building. Please do not walk from the waiting room toward the therapy rooms or hallways. This will impede the flow of traffic necessary to evacuate the building safely.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE POLICIES.

Signature of Responsible Parent: _____Date:_____

Printed Name:_____

INSURANCE AND BILLING INFORMATION

PPO Insurance Plans

We do not bill your insurance company for your child's therapy but will be glad to assist you in this. You will need to obtain a Doctor's prescription for your child's therapy. Payment will be expected at time of service and you will subsequently receive a receipt stating diagnostic and procedure codes used during your child's therapy session. You will be able to use that information when submitting your claim to your insurance company.

HMO Insurance Plans

Physician's Medical Group is the only HMO plan that we are contracted with. Services must be pre-authorized. These plans require pre-authorization which is requested by your primary care physician. We will bill your insurance, as a courtesy, providing we have a current authorization in writing. *We require copayments, co-insurance, deductibles, and non-covered charges to be paid at the time of service. The member's insurance benefit is a contract between the member and the insurance carrier. If you do not agree with the way your

insurance processes the claim, it is your responsibility to get it corrected by contacting them. It is your responsibility to keep us updated with your correct insurance information. If the insurance information you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan. All charges not covered by your insurance company are your financial responsibility. If your insurance does not pay or denies your child's claim, it is your responsibility to call them and follow-up on all your unpaid claims. You will need to keep track of your authorized number of visits. If after 60 days they have not paid, payment will be expected from you.

EOB's (Explanation of Benefits):

This is a document from your insurance company informing you of how they have processed your claims. It is your responsibility to review these when received. If you do not understand them, you need to call your insurance company directly. We will receive our copy 2-3 weeks later. If they do not pay your claims, you're responsible to find out why.

Notes/Documentation/Progress Reports:

Your insurance company will require us to send daily notes of treatment, current doctor's prescription, and current progress report. This means your claims are "Pending" and will not be paid or processed until they receive our records and review for processing. If a progress report is needed by your insurance company to justify ongoing services, it will be your responsibility to pay for that report time.

Notice of privacy practices acknowledgement

By my signature below I, acknowledge that I received a copy of the Notice of Privacy Practices for Pediatric Therapy Center.
Signature: _____

Divorced parents

Pediatric Therapy Center will not get involved in custodial, separation or financial disputes involving or related to divorced parents of a minor child. The parent who is the guarantor for the policy covering the child is the responsible party for payment of services rendered.

Returned Checks

For returned checks we assess a $25.00 NSF charge and expect a new payment within 7 days.

Release of Information

I understand that I, (as well as the policyholder) am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Pediatric Therapy Center to Release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Additional Information

I understand, it is my responsibility to get an initial prescription from our medical doctor. I do not hold PTC responsible for any back billing. I understand I will bill my own insurance for treatment that has already been provided by PTC.

I being the parent/guardian/policy holder understand that ultimately I will be responsible for all fees for service. I have read, understand and agree to the above financial information policy for payment(s) of professional services and fee's.

Signature of Responsible Parent/guardian:

_____ **Date**_____