13895 W. Wainwright Drive
Boise, Idaho 83713
T: 208-939-3334 F: 208-939-1122

CHILD'S INFORMATION

Today's Date:			
First Name:	Last Name:	☐Male	☐ Female
Address:	City:	State:	Zip:
Physical Address if PO Box:			
Birth Date:	Age:		

GUARDIAN INFORMATION

Name:	Birth Date:	Relationship:
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )
Name:	Birth Date:	Relationship:
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )
Primary Email Address:		
Emergency Contact:_____ (In addition to guardians)		
Relationship to patient:	Home phone: ( )	Cell Phone: ( )
How did you hear about us? ☐Doctor ☐Friend ☐ Family ☐Phone Book ☐Internet ☐Church Other:		

GUARANTOR INFORMATON (PERSON RESPONSIBLE FOR PAYMENT)

**MEDICAID INSURED MUST ALSO COMPLETE THIS SECTION*

First Name:	Last Name:		
Address:	City:	State:	Zip:
Physical Address if PO Box:			
SSN:			
Birth Date:	Age:		

CHILD'S SCHOOL (IF APPLICABLE)

School Name: Grade:	
Hours Patient Attends school:	School Phone Number:

PREVIOUS OR OUTSIDE SERVICES

☐ OT ☐ PT ☐SLP(SPEECH THERAPY) ☐ DT (DEVELOPMENTAL THERAPY)

Please List Therapist/Frequency of Services:
Do You Have an IEP/IFSP? ☐ Yes ☐No
Do You Have a Service Coordinator? ☐ Yes ☐ No
If Yes, Please Name:

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PRIVACY NOTICE

This notice describes how information about you may be used and disclosed and how you can get access to this information.

We are required by law to maintain the privacy of your health information and to give you notice of our legal duties and privacy practices with respect to your protected health information. This Notice summarizes our duties and your right concerning your protected health information. Our duties and your rights are set forth more fully in 45 CFR part 164. We are required to abide by the terms or our Notice that is currently in effect.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit Idaho Pediatric Therapy Clinic a record of your visit is made. Your physical therapy records include your symptoms, examination, test results, diagnoses, treatment, and a plan for future care or treatment. Your physical therapy records are used for:

· a basis for planning your care and treatment
· a means of communication among the many health professionals who contribute to your care
· a legal document describing the care you received
· a means by which you or a third-party payer can verify that services billed were actually provided
· a tool in educating health professionals
· a source of data for medical research
· a source of data for our planning and marketing
· a source to review for quality assurance of future patients.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy; better understand who, what, when, where and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of Idaho Pediatric Therapy Clinic, the information belongs to you. You have the right to:

· obtain a paper copy of this Notice of Privacy Policies upon request
· inspect and copy your health record as provided for in 45 CFR 164.524
· amend your health record as provided in 45 CFR 164.528
· obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
· request communications of your health information by alternative means or at alternative locations
· request a restriction on certain uses and disclosures of your information as provided by 45 CFR *164.522*
· revoke your authorization to use or disclose health information except to the extent that action has already been taken

OUR RESPONSIBILITIES

Idaho Pediatric Therapy Clinic is required to:

· maintain the privacy of your health information
· provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
· abide by the terms of this notice
· notify you if we are unable to agree to a requested restriction
· accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

CHANGES TO THIS JOINT NOTICE

We reserve the right to change the terms of our Notice of Privacy Practices at anytime, and to make the new Notice
provisions effective for all protected health information that we maintain. If we materially change our privacy practices, we will prepare a new Notice of Privacy Practices, which shall be effective for all protected health information that we maintain. We will post a copy of the current Notice in our clinic and on our website. You may also obtain a copy of the current Notice by contacting us.

COMPLAINTS

If you believe your privacy rights have been violated, you can file a complaint with Idaho Pediatric Therapy Clinic Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. All complaints must be in writing. We will not retaliate against you for filling a complaint.

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

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ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Idaho Pediatric Therapy Clinic's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

X

X _____

Patient's / Guardian's Signature

Date

If not signed by the patient, please indicate your relationship to the patient (e.g., spouse).

X _____

Relationship ***Witnessed by***

INTERNAL USE ONLY

If the patient or representative refuses to sign this form, document the date and time the notice was presented and sign below.

_____

Presented on (date and time) *Signature of Deliverer*

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_____ *initial*

CONSENT FOR CARE AND TREATMENT

I give my consent to Idaho Pediatric Therapy Clinic to evaluate my dependent's condition and furnish treatment as considered necessary and proper by the Therapist.

_____ *initial*

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I request that payment of authorized benefits be made on my behalf to Idaho Pediatric Therapy Clinic or parent company, Idaho Spine & Sport Physical Therapy for therapy services furnished to me.

_____ *initial*

RELEASE OF MEDICAL INFORMATION

I authorize any holder of medical information about me to release to my insurance(s) (private / auto insurance(s); and/or work comp insurance(s); and/or the Centers of Medicare and Medicaid Services and its agents) any information needed to determine these benefits or benefits for related services. I also authorize Idaho Pediatric Therapy Clinic / Idaho Spine & Sports Physical Therapy to discuss my medical condition with any other medical provider(s) who have, are, or will be participating in my medical care.

_____ *initial*

CHANGE OF INSURANCE POLICY

In the case of an insurance change (primary, secondary, or both) I agree to alert my Therapist as soon as possible and to present them with my new insurance card(s) to copy for their records. I understand that failure to adequately inform my physical therapist of a change within a timely manner may result in my treatment being unpaid by my new insurance, particularly in the case that pre-authorization of treatment needed to be obtained, making me fully responsible for payment of those dates.

_____ *initial*

CANCELLATION / NO SHOW POLICY

I have been provided with and understand the Cancellation Policy. I understand that this policy is strictly enforced and agree to its conditions.

_____ *initial*

FINANCIAL POLICY (Does not apply to Medicaid UNLESS you are subject to Medicaid copay which will be verified with your insurance benefits.)

We bill your insurance company solely as a courtesy to you. If your insurance carrier does not make payments within 60 days, you agree to begin making monthly payments with a minimum payment of 20% of your outstanding balance or $50 whichever is greater. After 60 days of an outstanding balance, a monthly interest fee of 1.5% will be applied to your balance and compounded monthly (18% annually). You may arrange a payment plan upon request. **If any payment is made directly to you for services billed by us, you agree to promptly remit same to Idaho Pediatric Therapy Clinic.**

_____ *initial*

MEDICAID AS A SECONDARY INSURANCE POLICY

I understand that if I fail to meet my primary insurance guidelines and benefits, any unpaid balance after Medicaid processes as a secondary insurance will be my responsibility for payment.

**For further clarification of this policy, please refer to our front office or billing staff.*

I have read, understand and agree to the above conditions

X_____

Responsible Party ***Date***

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PRIVATE INSURANCE POLICY

FINANCIAL RESPONSIBILITY

I have read and understand the following: Idaho Pediatric Therapy Clinic (IPTC) or parent clinic, Idaho Spine & Sports Physical Therapy (ISSPT) bills insurance solely as a courtesy. Coverage Information provided to me by IPTC comes from information obtained from my insurance based on the information I provided. This information is not a guarantee of payment and there is a possibility that this information is not accurate. It is ultimately my responsibility to know and understand my own insurance benefits and coverage. I agree that I am responsible for payment of services even if my insurance denies payment.

BILLING PROCEDURES

IPTC will help you estimate your cost per visit. Costs vary based on procedures performed, treatment duration and contractual agreements with insurance companies. Your estimated share or **co-pay is due at the time of each visit**. This also applies to those subject to Medicaid copays. If this is not feasible, you may arrange a payment plan.

You will receive a bill once a month. Because we are often waiting on payment and contractual adjustments from your insurance, the amount due on your bill will only reflect the treatments that have been addressed by your insurance. It will separately show charges that are pending insurance responses.

To avoid interest charges, you agree to pay 20% of the amount due or $50 (whichever is greater). If this is not feasible, you can still avoid interest charges by setting up a payment plan with our billing department. If the minimum amount due is not paid or you have not arranged a payment plan, your account will be charged an interest fee of 1.5% monthly (18% annually).

In the event that payment is not received two months in a row, your account will be turned over to a collection agency.

If any payment is made directly to you from your insurance company for services billed by us, you agree to promptly assign or endorse such payment to Idaho Pediatric Therapy Clinic.

I understand and agree that if I fail to make regular payments as described above, I will be responsible for all costs of collecting monies owed, including interest fees, court costs, collection agency fees, and/or attorney's fees.

I have read, understand and agree to the above conditions.
I understand my full responsibility for the payment of my account.

X _____
Patient / Guardian ***Date***

X _____
Idaho Pediatric Therapy Clinic Representative ***Date***

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ATTENDANCE POLICY

Each child we treat has their own individual and specific therapy goals and needs. Due to time and insurance constraints, most kids are scheduled at very conservative frequencies. At these low intervals of treatment, it becomes imperative that caregivers make every possible effort to have their child at all scheduled appointments. Due to each family's unique scheduling needs, putting together a workable calendar for each therapist is a bit like putting together a jigsaw puzzle. When a child's scheduled appointment time is missed, it has an impact on many levels. The child misses vital therapeutic treatments, it jeopardizes the therapist's valuable time, and it is a disservice to those on our wait-list who are willing and able to make therapy a priority. In fairness to everyone, we strictly enforce our attendance policy.

ATTENDANCE TO ALL SCHEDULED VISITS IS EXPECTED

- **Cancellations made less than 24 hours in advance will be subject to a $40 fee**
- **Payment of fee must be paid at the next treatment session**
- **Arrivals to appointments 15 minutes or later scheduled time is subject to the no-show/cancellation fee even if the child is treated for the remaining time available**
- **Efforts to re-schedule are encouraged if there is availability**
- **Re-schedules should be made in good faith in regards to patient availability/transport. Cancellation of a re-schedule will continue to be subject to the $40 fee**

When monitoring attendance, family emergencies, serious medical conditions, and surgeries will be considered. If your child's therapist is absent for vacation/illness it will not affect your attendance. However, you are still expected to attend your other therapy sessions, even if they are back-to-back sessions. Additionally, if you have out of town visitors they are more than welcome to come observe treatment.

POSSIBLE ACCEPTABLE REASONS TO CANCEL AN APPOINTMENT:

Illness: A certain level of typical childhood illness is expected and should not limit your child's ability to receive treatment that day. Acceptable causes for cancellation are: fever over 100°, vomiting, diarrhea, unknown rash, onset of cold, hospitalization & doctor-specific reasons

Medical Procedures: We expect you to try to schedule other appointments around therapy but occasionally this will not be possible. Please advise us as soon as you are aware of a conflict so we can re-schedule that appointment.

Family Emergencies

Vacation: We require a 10 day notice on any scheduled vacations. Any vacation scheduled longer than 2 weeks may result in forfeiting any reserved time slots. Please discuss this with individual provider(s) if you are planning a long vacation. Therapy team will discuss available options with you once it is reviewed.

Other: All reasonable exceptions will be considered on a case by case basis.

I have read, understand and agree to the above conditions

X_____

Responsible Party ***Date***

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Medical Questionnaire

Name: _____

Diagnosis: _____ Date of Onset: _____

Medical Specialists: _____

Please list all pertinent surgeries:_____

Please list all medications: _____

Does your child have any allergies? ☐ No ☐ Yes If yes, please list: _____

How do you calm / soothe your child?_____

What are your goals for therapy here?_____

Does your child have pain? ☐ No ☐ Yes

If yes, please mark the areas of concern and any other notes you would like to add: