

In Harmony Pediatric Therapy

New Patient Information Form

Child's Name (as appears on insurance card): _____ DOB: _____ Gender: M or F

Parents' Names: _____

Address: _____ City _____ Zip _____

Please circle preferred method of communication.

Phone Number: _____ Cell Phone Number: _____

E-mail: _____

Emergency Contact (other than person bringing child to therapy) _____

Diagnosis (if known): _____

Primary Physician: _____

Physician's Phone and Address: _____

Referring Physician (if different): _____

Other doctors and specialists who are involved in your child's care:

Name	Specialty	Phone Number

Insurance Information:

_____ I decline use of my insurance and will pay at the time of service

Primary Insurance: _____ Name of Insured: _____

Insured SS #: _____ Member ID: _____ Group #: _____

Claims Address (found on back of card): _____

Cust Service #: _____

Secondary Insurance: _____ Name of Insured: _____

Member ID: _____ Group #: _____

Claims Address (found on back of card): _____ Cust Service #: _____

Medicaid Number: _____ Effective Date: _____

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Family Background

Mother's Name: _____ DOB: _____ Occupation _____

Father's Name: _____ DOB: _____ Occupation _____

Marital Status: Single Married Divorced Separated Widowed

Languages Spoken at Home (circle primary): _____ Religious Preference _____

Is your child adopted? Y N Adoption Background: _____

What are your priorities in coming to therapy?

Has your child previously received therapy services? Yes No

If "Yes", where and when? _____

Medical History

At how many weeks was your child born? _____ Birth weight? _____

Were there any complications during the pregnancy or delivery? Yes No Please describe: _____

Was your child hospitalized after birth? _____

Does your child have any other medical issues? _____

Please list any hospitalizations and/or medical procedures or significant family history:

ALLERGIES

Please list all known allergies that your child has.

Reaction:

1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

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Current medications:

Name	Dosage	Frequency	Reason for medication

Education Information

Is your child currently enrolled in school? Yes No

If "Yes", where and days attended: _____

Does your child receive any services through the school? Yes No

If "Yes", what services? _____

Does your child have a current Individualized Education Plan (IEP) or IFSP? Yes No

Date of last review: _____

Social/Emotional History

What are your child's favorite toys/activities? _____

What are your child's favorite songs? _____

Is your child currently enrolled in any community activities (music class, play groups, Mother's Morning Out Program)? _____

Anything else you would like to tell us about you or your family? _____

How did you hear about In Harmony Pediatric Therapy? _____

Name of Person Completing This Form

Relationship to Child

Date

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Financial and Insurance Policy Effective 1/1/2014

Thank you for choosing *In Harmony Pediatric Therapy*, a collaboration of providers with Grow With Me Pediatric Physical Therapy, Inc., Rising Stars Children's Therapy, Inc., and Therabeat, Inc. **The above mentioned companies are the companies that will bill your insurance, not *In Harmony Pediatric Therapy*. Please understand this when searching for participating providers in your network and when reading your insurance statements.** The following information explains our billing and financial policy. Please do not hesitate to contact us regarding questions about billing/payments.

Therabeat, Inc. is out of network for all providers and BCBS does not pay for music therapy. RSCT & GWM are in-network providers for BCBS, Cigna and Humana PPO/PAR/HMO plans and RSCT is also in-network with United Healthcare. Claims will be submitted to insurance companies at a reasonable and customary rate. Benefits will be verified prior to the start of therapy. Information obtained from insurance companies is **not always a guarantee of payment.** Families are ultimately responsible for payment for non-covered services. **It is imperative that families are aware of their insurance coverage and their potential responsibilities.** Unless your child has Medicaid, families are responsible for all co-pays, coinsurances, and deductible expenses associated with each date of service. All companies within *In Harmony Pediatric Therapy* accept cash, check, VISA, MASTERCARD, and Discover. There is a \$50 fee for all returned checks.

If your child has Medicaid coverage, you are responsible for informing billing managers if there is a change in your child's Medicaid status. If Medicaid coverage has been terminated or is pending approval, and you continue with services, you will accept financial responsibility for the services rendered. **Therabeat, Inc. is not a Medicaid provider for music therapy services.**

If payment has not been received from the insurance company within 60 days from the date of service, the family will be responsible for the balance. If a family receives a bill that is not paid within 30 days of receipt of invoice, there will be a **\$35 late fee charge and an 18% annual interest fee (1.5%/month).** Any lawyer and court fees will also be the responsibility of the family.

If you do not have insurance coverage for therapy services or opt-out of using your insurance, our billing managers will discuss private payment options with you.

Parent/Legal Guardian Signature

Date

ATTENDANCE POLICY ** UPDATED FOR 2014***

Your child's progress depends on your family's commitment to therapy. When you schedule an appointment with our clinic, you are "reserving" the therapist's time. Therefore, we must adhere to the following strict cancellation policy.

In Harmony Pediatric Therapy's policy states that we require a 24-hour notice for cancellations. After a one-time courtesy occurrence, a **\$50 cancellation fee will be charged for EACH missed therapy appointment. Please note that insurance cannot be billed for this fee and you will be personally responsible for this charge.** We will consider waiving this charge if you are able to **reschedule your missed appointment.**

If attendance becomes an issue and you are not able to make your appointments, understand that we will need to discuss other options as we may not be able to hold your slot.

All of our therapists work with medically fragile children and we don't want to carry sickness to other families, infect ourselves, or our own families. Please be respectful and cancel your therapy appointment if your child is sick. You will not be charged a cancellation fee for sickness and we will

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work to reschedule your appointment when your child is healthy. The Board of Health considers the following signs to indicate communicable disease/illness: **Vomiting, Fever over 100 degrees, Diarrhea, Sore throat, Rash/Swelling, Red, or running eyes.** Please be sure your child is symptom free for 24 hours before resuming therapy.

Our therapist's time is very valuable and the duration of therapy sessions are catered to your child's needs. Please arrive on time for you appointment and 15 minutes prior to the end of the session.

Parent/Guardian Signature: _____ **Date:** _____

Consent to Treat

I, _____ consent for In Harmony Pediatric Therapy to provide my child, _____ with Occupational, Physical, Speech Therapy, and/or Music Therapy services. I consent to care and treatment falling under the practice guideline of the American Occupational Therapy Association (AOTA), American Speech-Language-Hearing Association (ASHA), American Physical Therapy Association (APTA), American Music Therapy Association (AMTA), and the State of Georgia.

I acknowledge that there is always a risk of injury with any therapy involving physical activities and equipment. IHPT is NOT responsible for any injury associated with equipment use when your child is not with a treating therapist. You are responsible for making your therapist aware of any changes to your child's physical or mental condition. IHPT is a teaching facility and supervised students and volunteers may participate in your child's treatment session.

Parent/Legal Guardian

Date

I have read, understand, and agree to the In Harmony Pediatric Therapy, HIPAA Notice of Privacy Practice.

Signature: _____ **Date:** _____

Permission for Exchange of Medical Information

All documents will be sent electronically. There will be a \$.75 per page charge for all printed documents, payable at time of pick-up.

_____ I decline any information exchange

I authorize In Harmony Pediatric Therapy to release and communicate necessary and pertinent medical information to physicians, case managers, and insurance companies as needed for my child, _____.

Approved information may be given to, received from, and discussed with the following people *directly* related to my child's care:

- Other Therapists _____
- School Name _____
- Please list any other/s _____
- Please indicate any custody, divorce or family matters we should be aware of _____

Approved information includes **written documents** and/or **verbal discussion**.

Parent/Guardian Signature

Date

Printed Name

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Updated 1/1/2014

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Permission for Family to Leave Site During Treatment

____ I decline permission to leave facility

I, _____, acknowledge that I am the parent of _____.
I understand that while my child is receiving therapy I may leave the premises. However, I understand that I will give to In Harmony Pediatric Therapy a working cell phone number where I can be reached during my absence. In addition, I agree that I will not travel more than **ten miles** from the satellite and will return **15 minutes prior** to the end of the session. I give consent and permission to In Harmony Pediatric Therapy for any additional treatment or transportation that may be needed in the event my child is injured or needs medical attention. I understand that failure to comply with the requirements listed above will result in immediate revocation of this ability. Also, I understand that the ability to continue to leave the premises while my child is in therapy is at the discretion of In Harmony Pediatric Therapy and/or the therapist and may be revoked at any time.

I hereby release In Harmony Pediatric Therapy, and any agents as well as any assignees, from any and all claims for damages related to my leaving the premises during my child's therapy.

Cell Phone Number: _____

Signature

Printed Name

Date

Secondary Emergency Contact Name & Phone Number

Consent for Audio/Visual Release

____ I decline the taking of audio/visual material

I _____ give permission for _____ to be audio or video taped by the therapists at In Harmony Pediatric Therapy. These audio or video taped sessions will be used for education and training purposes only (i.e., clinical supervision, conference presentations). At no time will your child's full name be spoken on the tapes and your child's full identity will remain confidential. These tapes may be maintained in a locked facility.

Signature of parent/guardian: _____ Date: ____/____/____

Consent of Photograph Release

____ I decline the taking of photographs

I _____ give permission for my child _____ to be photographed by the therapists at In Harmony Pediatric Therapy. These photographs will be used for education and training purposes (i.e., clinical supervision, conference presentations), and may be used by In Harmony Pediatric Therapy for advertisement purposes (i.e., brochures, Facebook, Twitter, newspapers). Names and child's information will be kept confidential.

Signature of parent/guardian: _____ Date: ____/____/____