Pediatric Rehab

PATIENT INFORMATION SHEET

Personal Information

First Name: _____ Middle Initial: _____ Last: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Mailing Address _____ City _____ State: _____ Zip: _____
Home Phone: (____) _____ Cell: (____) _____ Work: (____) _____
SSN: _____ - _____ - _____ DOB: __ / __ / _____ Gender: M___ F___
Referring Doctor: _____ Primary Care Provider: _____
Primary Diagnosis: _____ Secondary Diagnosis: _____

Can we communicate with you by Email? Yes / No Email address _____ (optional)

Parent Information

Mother's Name: _____ Phone: (____) _____ SSN: __ __ __ - __ __ - __ __ __ __
Address (if different): _____ Employer: _____
Father's Name: _____ Phone: (____) _____ SSN: __ __ __ - __ __ - __ __ __ __
Address (if different): _____ Employer: _____
Marital Status: Single: ___ Married ___ Other ___

Emergency Contact or Legal Guardian Information

Name: _____ Address: _____ City: _____ State: _____ Zip: _____
Work/Cell Phone: _____ Home Phone: _____
Relationship: Emergency Contact ( ) Parent ( ) Guardian ( )

Insurance Information

Primary Insurance: _____ Policy Number: _____
Policy Holder Name: _____ Policy Holder Phone: (____) _____
Policy Holder DOB: __ / __ / _____ Policy Holder's SSN _____ - _____ - _____
Policy Holder Address (if different): _____

Secondary Insurance: _____ Policy Number: _____
Policy Holder Name: _____ Policy Holder Phone: (____) _____
Policy Holder DOB: __ / __ / _____ Policy Holder's SSN: _____ - _____ - _____
Policy Holder Address (if different from patient): _____

Please be advised it is your responsibility to consult your insurance regarding coverage for outpatient therapy.
We do check eligibility as a courtesy, but your failure to check could result in an unpaid bill for which you are responsible.
I understand it is my responsibility to notify HPRC of any and all changes to health insurance coverage.

_____	_____	_____
Signature of Responsible Party	**Name of Responsible Party**	**Date**

WELCOME TO THE HUMAN PERFORMANCE AND REHABILITATION CENTERS, LLC

Your physician has referred your child to the Human Performance and Rehabilitation Centers, LLC ("HPRC") for treatment by a physical, occupational or speech therapist.

The following information will give you a better understanding of our payment and insurance filing policies:

PAYMENT POLICY: Payment is requested at the time of service unless other arrangements are made prior to treatment. We accept cash, check, MasterCard, Visa or American Express and most Health Savings and Flexible Spending Accounts.

INSURANCE: HPRC will file your child's primary and secondary insurances if you provide the appropriate insurance information. You should contact the insurance company if you believe they have incorrectly paid your claim. This office will not negotiate the settlement of a disputed insurance claim. Please notify our office each time your child's insurance changes so we can file claims correctly.

MANAGED CARE CONTRACTS: HPRC is enrolled in numerous managed care and participating provider insurance programs. Please advise our staff if your child is a member of this type program. Our participation is not a guarantee of payment from your insurance.

MEDICAID: The therapists at HPRC are participating Medicaid providers. We will file with Medicaid and one private insurance if you provide us with the appropriate insurance information.

LEGAL CASES: We cannot treat patients on a contingency basis; therefore, where legal cases are pending settlement, we ask that the full charge be paid at the time treatment is rendered.

PATIENT RESPONSIBILTIY: All co-pays or estimated patient balances are due at time of service. You will receive a statement each month for any remaining balance after insurance has responded to our claim. You are responsible for that balance. Pay only amounts in patient responsibility on your statement.

IF YOU HAVE ANY QUESTIONS, SOMEONE FROM OUR BUSINESS OFFICE WILL BE GLAD TO ASSIST YOU.

CONSENT FOR TREATMENT & AUTHORIZATION: I _____, the parent or guardian of _____ (thereafter referred to as "my child", do hereby consent to treatment of my child by Human Performance and Rehabilitation Centers, Inc. I authorize HPRC to release medical and supporting documentation of same as compiled in my child's medical record during this treatment or subsequent treatments for purposes of benefit payment. I further authorize my insurance benefits to be paid directly to Human Performance and Rehabilitation Centers, Inc. when indicated on claim. I understand that I am financially responsible for the charges for services rendered.

_____
Patient Name

By:_____ Date: _____
Signature of Responsible Party

_____
Description of Representative's Authority

(PedCons, Rev. 12/18)

Human Performance and Rehabilitation Centers, LLC

Consent to Emergency Care

Human Performance and Rehabilitation Centers, LLC's policy is for the parent/legal guardian to remain on-site while their minor child is receiving therapy, However, under certain circumstances, if the parent/legal guardian has to leave the premises, we request that this form be completed in order to allow us to obtain emergency care until which time the parent/guardian is contacted and is able to assume responsibility for the minor child

As the parent/legal guardian of, _____ I request that in my absence, the above-named minor child be admitted to any hospital or medical facility, including a physician's office, for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatments of the condition of the above named.

I give permission for Human Performance and Rehabilitation Centers, LLC to communicate with health care providers concerning minor's health and health records. I waive any HIPAA or State privacy privilege for the limited time required until an authorized family member or guardian is present.

I give my consent on the minor patient's behalf in my capacity as:

Parent _____Guardian _____ Adult Brother/Sister _____Grandparent _____Caregiver _____

Phone: Home: _____ Work Phone: _____ Cell Phone: _____
Signature: _____ Date: _____
Name of Parent/Legal Guardian: _____
Address: _____
City/State/Zip: _____
Person to Notify if parent/ legal guardian is unavailable: _____
Child's DOB: _____ Child's SS#: _____
Doctor's Name: _____ Doctor's Phone: _____
Insurance Company: _____Insurance Policy #: _____
Date of last Tetanus Booster_____
Allergies of child, including any to medicine: _____
_____
Other medical problems which should be noted: _____
_____

ACKNOWLEDGEMENT OF NOTICE OF INFORMATION PRACTICES

(To be retained by Medical Provider)

I understand that Human Performance and Rehabilitation Centers LLC (referred to below as "the clinic") will use and disclose health information about my child in the course of providing treatment.

I understand that my child's health information may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my child's health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand that the clinic is permitted to use and disclose my child's health information in order to:

- make decisions about and plan for my child's care and treatment; • refer to, consult and coordinate with other health care providers in the course of my child's treatment;
- determine my child's eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my child's health care; and e perform various office, administrative and business functions that support the clinic's ability to provide my child with appropriate care and arrange for payment.

I also understand that I have the right to receive a written Notice of Privacy Practices that describes how the clinic uses and discloses health information, the information practices followed by the clinic staff and rights regarding my child's health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request. I also understand that a copy of the most current version of the clinic's Notice of Privacy Practices in effect is posted in the waiting/reception area. If requested, we will provide you with a copy of this Notice.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my child's health information not be used or disclosed, and I understand that the clinic is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I will be provided with a copy of the Notice of Privacy Practices upon request.

Patient Name: _____ Date: _____

Signature of Responsible Party: _____

Description of Representative's Authority: _____

Pediatric Rehab

APPOINTMENT POLICY

HPRC Pediatric Rehab greatly cares about the health and well-being of the children we serve.

Consistent attendance is very important to your child's progress. We understand sometimes circumstances occur that prevent your child from coming to their scheduled appointment.

Effective immediately:

_____ You must **CALL TO CANCEL** your appointment if you are unable to make it, before your appointment time. A 24-hour notice is preferred.

_____ If you are late for an appointment, more than 8 minutes, your child may or may not be seen. Appointment may need to be re-scheduled. However, if your child is seen, their appointment will be abbreviated.

_____ If an appointment is **NOT canceled**, it will be considered a **NO SHOW**. A **NO SHOW** occurs if your child is not at their scheduled appointment within 15 minutes of the appointment time. A notification will be sent to you through instant messaging, letting you know of the missed appointment. If you call to cancel following receiving a NO SHOW text message, the NO SHOW can not be changed to a cancel.

_____ ***** If you **NO SHOW 1 time**, your child will be removed from the schedule if they have set "block" appointments. If **YOU** call to re-schedule the appointment, then they will be re-scheduled for only 1 appointment at a time. If another NO-SHOW occurs, then they will be discontinued from therapy for 3 months and the referring physician will be notified and a new prescription will be needed to return to therapy. *****

_____ Additionally, if you have **3 Cancelations** within 3 months, then your child will be removed from block scheduling and appointments will be scheduled one at a time.

Please make sure contacts numbers we have for you are current. _____
Remember, it's up to you to contact our office to re-schedule appointments.

Thank you for your understanding and cooperation. If you have any questions regarding this policy, please ask.

Signature: _____ Date:_____

Telehealth Member Consent Form

PATIENT NAME: _____

DATE OF BIRTH: _____

Insurance ID#: _____

1. PURPOSE: The purpose of this form is to obtain your consent to participate in a telehealth consultation in connection with the following procedure(s) and/or service(s):

_____

_____

2. NATURE OF TELEHEALTH CONSULT: During the telehealth consultation:

a. Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
b. A physical examination of you may take place.
c. A non-medical technician may be present in the telehealth studio to aid in the video transmission.
d. Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s)

3. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient- identifiable images or information for this telehealth interaction to researchers or other entities shall not occur without your consent.

4. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth consultation, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during this telehealth consultation.

5. RIGHTS: You may withhold or withdraw consent to the telehealth consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

6. DISPUTES: You agree that any dispute arriving from the telehealth consult will be resolved in Georgia, and that Georgia law shall apply to all disputes.

7. RISKS, CONSEQUENCES & BENEFITS: You have been advised of all the potential risks, consequences and benefits of telehealth. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telehealth consultation. All your questions have been answered, and you understand the written information provided above.

I agree to participate in a telehealth consultation for the procedure(s) described above.

Signature: _____ Date: _____
If signed by someone other than the patient, indicate relationship: _____
Whiteness Signature: _____ Date: _____