Pediatric Rehab

Physical Therapy - Occupational Therapy - Speech Therapy

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**

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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: _____

Relationship to patient: _____

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COVID-19/Coronavirus Medical History Addendum

Thank you for coming in today. As you know, the world is experiencing an expanding outbreak of respiratory illness (COVID-19) caused by a new coronavirus.

We take our role in protecting the health of our patients and staff very seriously. Before entering our facility, we respectfully ask you to ***confirm the following:***

- ☐ You are not currently sick with:
  - Fever
  - Cough
  - Shortness of Breath
- ☐ You have not been in close proximity with someone who is currently sick with COVID-19 or any other respiratory illness within the last 14 days.
- ☐ You have not recently traveled from an area with widespread or ongoing community spread of COVID-19?

Please reach out to a staff member if you have any questions or concerns.

Thank you!

Name:_____

Signature:_____

Date: _____

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Financial Policy

At Human Performance and Rehabilitation Centers (HPRC) we are sensitive to the ever-changing healthcare environment and associated costs for our patients. We make it our policy to: A) Provide you with as much transparency as possible regarding your financial responsibility at each visit, and B) Make it easy and convenient for you to pay your portion of the cost of your services.

1. First, we ask every patient to provided credit/debit card or Automated Clearing House (ACH) information. Your credit/debit card or ACH information is stored securely in accordance to Payment Card Industry (PCI) compliance laws and is not accessible to the members of our practice in any way.

2. Then, we give you an estimate, based on your current remaining deductible, of what your potential financial responsibility could be after your insurance company processes your claim.

3. Next, you authorize HPRC to charge your credit/debit card or deposit account on file up to the amount of the estimate, as well as any additional amount you authorize. A receipt will be provided to you each time we charge your credit/debit card or deposit account.

4. Lastly, we collect your email address to send notifications or electronic statements if you have a balance due after your insurance company(s) process your claim.

(Please initial each statement after reviewing):

_____ I authorize HPRC to send electronic billing statements to my email address on file. I understand I will not receive a copy of any such statement via the U.S. Mail. I understand it is my responsibility to maintain a current email address on file with HPRC at all times.

_____ I understand this authorization will remain in effect until I provide written notice of cancellation to HPRC. I understand I can cancel the authorization only for future services.

_____ I understand it is my responsibility to provide HPRC with accurate insurance information to ensure proper billing. I understand my insurance company(s) may deny payment of claims related to services rendered if I fail to provide accurate insurance information and I may be responsible for my entire account balance.

_____ I understand it is my responsibility to obtain all referrals and authorizations prior to receiving care by HPRC.

_____ I understand if I do not cancel an appointment at least 24 hours before the scheduled appointment, I will be subjected to a $20.00 fee which is required to be paid before receiving any additional care. This fee will not be billed to insurance.

_____ Patient Name

_____ Phone Number

_____ Patient Name as it Appears on Card or Account

_____ Cardholder/Accountholder Email Address

_____ Cardholder/Accountholder Billing Address

_____ City

_____ State

_____ Zip Code

_____ Cardholder/Accountholder Signature

_____ Date

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE
(To be retained by Medical Provider)

I understand that HPRC (referred to below as "the clinic") will use and disclose **health information** about me in the course of providing rehabilitation care to me.

I understand that my **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 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 health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult and coordinate with other health care providers in the course of my treatment;
- determine my 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 health care; and
- perform various office, administrative and business functions that support the clinic's ability to provide me 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 my rights regarding my 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 or a summary of the most current version of the clinic's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my 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 <u>have received</u> a copy of the Notice of Privacy Practices.

By: _____ Date: _____
(Patient)

-OR-

By: _____ Date: _____
(Patient representative)

Description of Representative's Authority: _____

RSOC/HPRC 4/2003

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Telehealth Member Consent Form

PATIENT NAME: _____

DATE OF BIRTH: _____

GA MED 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: _____

Witness Signature: _____ Date: _____

WELCOME TO THE HUMAN PERFORMANCE AND REHABILITATION CENTER

Your physician has referred your child to the Human Performance and Rehabilitation Centers, LLC (HPRC) for treatment by a phys ical , 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 your child's treatment. We accept cash, check, MasterCard or Visa.

INSURANCE: HPRC will file your primary insurance if you provide the appropriate insurance information. You will receive a statement each month if your account has a balance. You are responsible for payment of that balance. If your insurance does not pay, you should contact the insurance company. This office will not negotiate the settlement of a disputed insurance claim.

HMO-PPO: HPRC is enrolled in numerous managed care and participating provider insurance programs. Please advise our staff if you are a member of this type program. All co-pays or estimated patient balances are due at time of service. Our participation is not a guarantee of payment from your insurance. You will receive a statement for any balance after insurance has responded to our claim.

MEDICAID: The therapists at HPRC are participating Medicaid providers. We will file your Medicaid and one supplement if you provide us with the appropriate insurance information. You will receive a statement each month until your account is paid out. Pay only amounts in patient responsibility on your statement. Medicaid will pay 80% of covered services after your deductible is met. You are responsible for your deductible and 20% of covered charges if your supplement does not pay timely. MEDICAID REQUIRES THAT YOU SEE YOUR PHYSICIAN AT LEAST EVERY 90 DAYS WHILE RECEIVING THERAPY. WE WILL REQUIRE A NEW REFERRAL TO DOCUMENT YOUR PHYSICIAN'S VISIT. MEDICAID REQUIRES THAT WE COMPLETE A PROGRESS NOTE EVERY 30 DAYS WHILE YOU ARE RECEIVING THERAPY.

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.

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

CONSENT FOR TREATMENT & AUTHORIZATION: I do hereby consent for treatment of my child at The Human Performance and Rehabilitation Center. I authorize HPRC to release medical and supporting documentation of same as compiled in my medical record during prior treatments, this treatment or subsequent treatments for purposes of benefit payment. I further authorize my insurance benefits to be paid directly to HPRC when indicated on claim. I understand that I am financially responsible for the charges for services rendered.

Signed_____ Date_____
Parent/Guardian

Relationship to Patient:_____

Witnessed By: _____

Revised 4/2011

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To All Parents/Guardians:

Due to the HIPPS privacy requirements, we can no longer allow siblings of patients into the treatment area.

The siblings accompanying the child to therapy need to stay in the waiting area of Pediatric Rehab for the duration of the visit.

We treat several patients at a time in our gym area. As such, it is impossible to keep parents and siblings from seeing other patients.

HIPPA prohibits us from allowing non-patients to see patients during treatment.

It is important that the child receiving therapy receives the complete attention of the treating therapist without any interruptions or distractions. At the completion of the treatment session, the therapist will discuss the results of the session.

If you must leave the waiting are, please notify the Office Manager. We recommend staying in the department until the completion of appointment.

We appreciate your understanding and cooperation in this matter.

The Pediatric Rehab Staff