Parent/Guardian Intake Form for Services

Childs First Name: _____ Middle Init: ____ Last Name:_____

Sex:____ Birth date:_____ Age:_____ Grade:_____

Diagnosis/Symtoms:_____

Parent / Guardian Names:_____

Address:_____

City:_____ State:_____ Zip Code: _____

Phone: (H)_____ (Wk)_____ (Cell)_____

Email:_____ Fax:_____

Primary Care Physician:_____

Clinic Name:_____ Phone:_____

Clinic Address:_____

School Attending:_____ School Phone#:_____

Teacher's Name:_____ School concerns:_____

_____

How did you hear about APT?_____

Your primary concerns about your child are:_____

_____

_____

Insurance Information and Authorization to Bill Insurance

Primary Insurance: _____

Policy #:_____

Group #:_____

Plan Name: _____

Subscriber: _____

Relationship: _____

Employer's Name: _____

Secondary Insurance: _____

Policy #: _____

Group #: _____

Plan Name: _____

Subscriber: _____

Relationship: _____

Employer's Name: _____

I authorize Advanced Pediatric Therapy to disclose medical information required for financial coverage to my insurance carriers and I authorize direct payment of medical benefits to Advanced Pediatric Therapy.

I understand that insurance coverage does not guarantee payment of services and that I, personally, am responsible for payment to Advanced Pediatric Therapy of all fees not covered or paid by my insurance.

Parent/Guardian Signature: _____ Date: _____

Agreement Between
Advanced Pediatric Therapy, LLC
And
_____ (Your Name)

Advanced Pediatric Therapy agrees to provide therapy services to_____ (child's name). Each session will be billed at the current rate. Advanced Pediatric Therapy will file a claim with most insurance plans for services provided by Advanced Pediatric Therapy, either as a provider or as an out-of-network provider. Advanced Pediatric Therapy will mail you a monthly invoice for services provided during the previous month for the full balance of claim not paid by your insurance company. If Advanced Pediatric Therapy does not participate in billing your insurance company or you are self pay, a monthly statement will be sent to you towards the end of each month for services provided during that month.

Client agrees to the following procedures:

REIMBURSEMENT – Payment is due in full within 15 days after receiving the monthly statement. If full payment is not received, your next therapy session will not begin. Failure to comply with our policy will result in forfeit of your therapy time slot. Unless other payment arrangements have been agreed upon by both parties, a 1% late fee will be assessed for any outstanding balances not received within 30 days upon receipt of patient statement. If payment is 90 days past due your bill may be sent to collections, unless a scheduled payment plan is agreed and signed by both parties.

Advanced Pediatric Therapy accepts payment by cash or check. A $15 service fee will apply to all checks returned for insufficient funds.

ILLNESS & CANCEILLATIONS – We encourage parents to cancel therapy sessions when your child is ill, a 24 hour notice is requested if possible. You will be charged ½ the price for missed sessions without any prior notification.

ATTENDANCE – Client agrees to attend all scheduled therapy sessions. However, illnesses and other emergencies do arise from time to time. Therefore, a minimum attendance of 80% (4 of every 5 sessions) of all therapy sessions is required in order to maintain your designated time period.

HOME PROGRAMMING – Parent agree to child participation in home programming assignment.

_____

Parent/Guardian's Signature Date

_____

Karen L. Myers, OTR/L Date
Advanced Pediatric Therapy

Consent/Release Form

Child's Name: _____

Picture and Video Release

_____I give permission for Advanced Pediatric Therapy to take pictures/videos of my child for the purpose of marketing/publicity. Pictures/videos used on APT website will be approved by parent before use.

_____I give permission for Advanced Pediatric Therapy to take pictures/videos of my child to be displayed within the APT facility.

_____I give permission for Advanced Pediatric Therapy to record videos of my child for the purpose of assisting evaluation or treatment observations.

_____I give permission for Advanced Pediatric Therapy to record videos for educational training of APT therapist.

_____I do not wish my child's picture/video to be taken for any purpose.

If at any time you no longer want your child's picture/video to be used for any reason by APT please inform us in writing.

Students and/or Volunteer Consent

_____I give consent for students and/or volunteers to observe and/or participate in the treatment of my child.
_____I do not give permission for students or volunteers to observe and/or participate in my child's treatment.

Consent to Release and/or Receive Medical Information

Advanced Pediatric Therapy has my permission to release and/or receive information on my child to following the following agencies or persons:

Pediatrician: _____

School/Teachers/Therapist: _____

Other: _____

Parent/Guardian Signature_____ Date: _____

Advanced Pediatric Therapy LLC. 6315 S 176th St. , Omaha. NE. 68135-3032 Office # 402-896-5982 Fax # 402-932-5123
WWW.APTNE.COM

HIPAA Disclosure Form
Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy and confidentiality regarding my medical information. I understand that the law permits my health information to be used or disclosed for the following services:

1. Treatment: Your medical information can be used to provide medical care among the multiple healthcare providers who may be involved in providing services directly and indirectly.
2. Payment: Your medical information can be used to obtain payment for the services we provide. For example we may give your health plan the information it requires before it will pay us.
3. Health Care Operations: Your medical information can be used to conduct normal healthcare operations such as quality assessments, to improve the quality of care we provide. We may use your medical information to authorize services or referrals.

Except as described in this Notice of Privacy Practices, health information that identifies you will not be disclosed without your authorization.

You have the following health information Rights

1. Right to request Special Privacy Protections
2. Right to request Confidential Communications
3. Right to Inspect and Copy
4. Right to Amend or Supplement
5. Right to an Accounting of Disclosures
6. Right to a Paper Copy of this Notice

I acknowledge that I have been informed of your Notice of Privacy Practices. I understand that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

Parent/Guardian Signature:_____ Date:_____