



PEDIATRIC THERAPY AND WELLNESS

568 Blue Ridge Drive Evans, GA 30809 • Phone (706) 364-5262 • Fax (706) 364-5263

DATE: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ DOB: _____ M F

Address: _____

City: _____ State: _____ Zip Code: _____

Please make sure to put the email address you would like appointment reminders to go to.

Phone: _____ Work: _____ Cell: _____

Email Address: _____

Father: Last Name: _____ First Name: _____ DOB: _____

SS# _____

Mother: Last Name: _____ First Name: _____ DOB: _____

SS# _____

Physician: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: **TRICARE** or **OTHER** _____

Sponsor/ Insured Name: _____ Sponsor SS# _____ DOB: _____

ID# _____ Group# _____

Relationship to Patient: _____ Employer/ Work# _____

Secondary Insurance: _____

Insured's Name: _____ Insured's SS# _____ DOB: _____

Relationship to Patient: _____ Employer/ Work# _____



PEDIATRIC THERAPY AND WELLNESS Notice of Privacy Rights and Practices

This Notice of Privacy Rights and Practices serves as the notice required by law to be proceeded to you and describes how your health information may be protected and disclosed in order to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. This notice also describes how you can access and control your past, present, and future physical or mental health or condition, related health care services, or your past, present, or future payment for healthcare.

The law requires that I protect the privacy of protected health information, and to provide you with a copy of this Notice, which describes my legal duties and privacy practices set forth in the Notice at any time with a New Notice. I am required to abide by the terms of this Notice until a New Notice becomes effective. The New Notice will be effective for all protected health information that I maintain as of the effective date of such New Notice's effective date. You may request a copy at any time.

Summary Information

Uses and Disclosures of Health Information

I use and disclose your health information about you for treatment, payment, and healthcare operations.

Treatment: I may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: I may use or disclose medical information about you so that the treatment and services you received may be billed to and payment may be collected from you, and insurance company, or third party. I may also use and disclose medical information about you to obtain prior approval or to determine whether your insurance will cover treatment.

Healthcare Operations: I may use or disclose your health information in connections with our healthcare operations. Healthcare operations include quality access and many improvement activities; such as, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, condition of training programs for healthcare professionals, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give written authorization to use or disclose your information to anyone for any purpose. If you give me an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, I cannot use or disclose your health information for any reason except those described in this notice.



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*Effective April 13, 2003 a new federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA) went into effect

Right to Amend: You have the right to request that I amend your health information. (Your request must be in writing and it must explain why the information should be amended.) I may deny your request under certain circumstances.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice at any time. To obtain a paper copy of this notice, please request on in writing from the contact information listed at the end of this Notice.

Questions and Concerns

If you have any questions or concerns regarding this notice or Ducktails Pediatric Therapy's privacy policies, please contact us at:

Office (706) 364-5262

Fax (706) 364-5263

568 Blue Ridge Drive

Evans, GA, 30809

If you are concerned that I have violated your privacy rights or you disagree with a decision that I made about access to your health information or in response to a request you made or restrict the use or disclosure of your health information or to have me communicate either you by alternative means or an alternative location, you may contact me using the information listed above. You may also submit a written complaint to U.S. department of Health and Human services.

I have received the Notice of Privacy Practices and I have had the opportunity to review it.

Patient Name: _____ Patient DOB: _____

Parent Name: _____ Patient Signature: _____

Today's Date: _____

Witness: _____



PEDIATRIC THERAPY AND WELLNESS

PLEASE READ AND SIGN THE FOLLOWING CONCERNING OUR OFFICE POLICIES AND ASSIGNMENT OF INSURANCE BENEFITS:

Payment is expected at time of visit unless prior arrangements have been made. All copays, coinsurance, and deductibles must be paid at the time of service.

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of my dependents. I further expressly agree and acknowledge that my signature on this document authorizes any therapist at Ducktails Pediatric Therapy and Wellness, Inc. to submit claims for benefits for services rendered or for services to be rendered, without obtaining my signature on each claim to be submitted for dependents and that I am bound by this signature as through the undersigned had personally signed the particular claim.

I, _____ hereby authorize _____

(Name of Insurance Company)

to pay and hereby assign directly to Ducktails Pediatric Therapy and Wellness, Inc. all benefits, if any, otherwise payable to me for services as described on the attached forms. *I understand that I am financially responsible for all charges incurred.* I further acknowledge that any insurance benefits when received by and paid to Ducktails Pediatric Therapy and Wellness, Inc. will be credited to my account in accordance with the above assignment.

(Authorized signature of Insured)

(Date)

I, _____, attest that the following insurer, _____

(Name of Insurance Company)

is the primary medical insurance carrier for, _____. Furthermore, there is

(Name of Child)

no other medical insurer responsible for payment of services rendered. I hereby give my full consent for the examination and treatment for the above named patient. I certify that I am a legal guardian or have been authorized by a legal guardian of the above named patient to consent for examination and treatment I am aware that payment remains my personal responsibility regardless of insurance or other third party involvement (including court orders). ***I understand that if at any time a claim is not paid or a refund is requested for having another primary insurance. I am responsible for the fees incurred.***

(Signature required for treatment)

(Date)

(Witness Signature)

(Date)



PEDIATRIC THERAPY AND WELLNESS

CONSENT FOR RELEASE OF MEDICAL RECORDS

I _____ the parent/legal guardian of _____ voluntarily and freely give my consent for the release **and/or** sharing of my child's medical records **to/from** Ducktails Pediatric Therapy & Wellness, Inc. I have had the opportunity to ask questions and receive information regarding the purpose of this release and the use of the medical records. I understand that this release may be withdrawn at any time. I also understand that these records are confidential.

Signature of parent/legal guardian _____ Date _____

Witness Signature _____ Date _____

****Below please list anyone that is able to have access to your child's information/records****

_____	_____
_____	_____
_____	_____
_____	_____



PEDIATRIC THERAPY AND WELLNESS

Video Surveillance

Ducktails Pediatric Therapy is now under video surveillance for monitoring purposes. I understand that all video material is the exclusive property of Ducktails Therapy and will not be used without prior written consent of the patient parent/legal guardian.

Parent/Legal Guardian Signature _____

Witness Signature _____



PEDIATRIC THERAPY AND WELLNESS

Toilet Training Policy

If your child is NOT toilet trained, you MUST remain in the immediate vicinity throughout your child's therapy session to be available to address any toileting needs.

Tardy Policy

Please be here five minutes prior to your child's scheduled appointment time. If you are more than five minutes late for your therapy session, the therapist reserves the right to not treat your child that day. You must be present in the waiting room five minutes prior to the end of your child's session.

Parent/ Legal Guardian Signature _____ Date _____

Witness Signature _____ Date _____



PEDIATRIC THERAPY AND WELLNESS

IMPORTANT PLEASE READ

Effective January 1, 2016

CANCELLATION/ATTENDANCE POLICY

We understand that there are occasions when you must miss appointments due to work or family situations. Please provide us with 24 hour notice when an appointment needs to be cancelled. Please note that our voicemail is time stamped, and we will get your message after business hours, the night before, or on the weekends.

ANY MISSED APPOINTMENT WITHOUT A 24 HOUR NOTICE OF A CANCELLATION WILL RESULT IN A \$25 FEE. THIS IS NOT COVERED BY INSURANCE. PAYMENT MUST BE COLLECTED PRIOR TO THE NEXT APPOINTMENT OR A BILL WILL BE SENT OUT. IF YOU HAVE AN EXCUSED NOTE, WE CAN WAIVE THE FEE FOR YOU. HOWEVER, THAT MISSED APPOINTMENT WILL STILL BE COUNTED TOWARDS YOUR ATTENDANCE IF IT HAS NOT BEEN RESCHEDULED.

Effective therapy requires consistent appointment attendance not just for the patient, but to adhere to insurance policy/regulations as well. All patients are required to attend 85% of appointments or they will need to schedule appointments on a week to week basis. At Ducktails, we strive to provide the highest level of care for all of our scheduled patients, while adhering to insurance guidelines for continued care. WE APPRECIATE YOUR COOPERATION IN THIS MATTER AND WE HOPE TO CONTINUE PROVIDING SUCCESSFUL TREATMENT TO OUR PATIENTS. THANK YOU!

I have read and understand Ducktails Pediatric Therapy & Wellness, Inc. cancellation and attendance policy.

Signature of Parent or Guardian _____ Date _____

Witness Signature _____ Date _____



PEDIATRIC THERAPY AND WELLNESS
PLEASE DO NOT LEAVE THE PREMISES
WHILE YOUR CHILD IS IN THERAPY.

As you wait in your vehicle, if an emergency occurs and you need to leave, please call the front desk or knock on the lobby doors so we can have your child brought out to you. We must enforce this policy due to our liability insurances as well as precautions for any medical emergencies that would need immediate assistance.

As a courtesy to our therapists, you **must be** outside your vehicle or in front of lobby doors to receive your child from their therapy session.

Should you choose to leave our site during your child's therapy session, we will remove your child from the therapy schedule effective immediately.

Thank you for your cooperation.

Parent/ Legal Guardian Signature _____ Date _____

Witness Signature _____ Date _____