Impressions
pediatric therapy

Exceptional Care For Your Children

WELCOME TO OUR PRACTICE

Please take a few minutes to answer the following questions so we can better assist you with your health care needs.

PATIENT INFORMATION

Name: _____Social Security #: _____Date of Birth: _____

Address: _____

City/State/Zip: _____

Home phone #: _____ Cell phone#:_____

Sex (circle one): Male Female E-mail Address: _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____

Phone: _____

PRIMARY INSURANCE

Person Responsible for Account: _____

Relationship to Patient: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____ Home phone: _____

Copay Amount: _____ Co-Insurance: _____

Visit Type: Occupational Therapy: _____ Speech Therapy: _____ Physical Therapy: _____

Insurance company: _____

Insurance company address: _____

Subscriber I.D. #: _____Group #_____

Authorization Required? Yes/No: _____ Referral Required? Yes/No: _____

ADDITIONAL INSURANCE (if applicable)

Insured name: _____

Relationship to Patient: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Insured Employed by: _____ Business phone: _____

Insurance company: _____

Insurance company address: _____

Subscriber I.D. #: _____Group #:_____

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REASON FOR VISIT

Please list your present health concerns, problems or diagnosis: _____

_____

_____

_____

_____

SCHOOL AND THERAPY SERVICES

School/program currently attending: _____ Present grade: _____

Special services received in school: _____ OT _____ PT _____ Speech Therapy _____

Resource services Special education _____ Behavior intervention _____Other special services _____

Does your child's teacher have concerns about your child's development in any of these areas:

_____ Motor skills _____ Social abilities _____ Self-help skills _____ Cognitive skills/learning abilities

Additional Comments: _____

Do you have an IEP from school? Yes ___ No ___ What does it cover? _____

_____

RELEVANT MEDICAL INFORMATION

1. Physicians currently involved in your child's care: _____Phone #:_____
2. Current diagnoses/infections (please list): _____
3. Recent hospitalizations: _____ No _____ Yes If yes, please describe: _____
4. Recent surgery: _____ No _____ Yes If yes, please describe: _____
5. Diagnostic tests: _____ Bone scan _____ MRI _____ CAT scan _____ Upper GI _____ Swallow study _____
6. X-rays Results: _____ ____
7. Medications your child currently takes: _____
8. Special equipment your child uses: ____Splint ____Braces ____Walker ____Crutches ____Wheelchair ____ Other
9. Previous psychological testing: _____ No _____ Yes Results of testing indicate (check all that apply):

_____ Learning Disability _____ Attention Deficit Disorder _____ Hyperactivity _____

Intellectual Disability_____ Developmental Delay _____ Autism/Pervasive Developmental Disorder

_____ Behavioral Disturbance_____ Depression _____ Needs Special Education Services _____ Other

10. Please check all that apply to your child (previous or current):

_____ Seizures _____ G-Tube _____ Food allergies _____ Wears hearing aids _____ Wears glasses

_____ Latex sensitivity _____ Hearing difficulty _____ Vision problem _____ Ear infections

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ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Impressions Pediatric Therapy for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above provider of services in the office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____Date_____

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FINANCIAL POLICY

Patient Name: _____ **Date of Birth:** _____

Thank you for choosing Impressions Pediatric Therapy for your child's therapy needs. Our mission at Impressions Pediatric Therapy is "helping you, help your child, achieve his or her goals".

Insurance Benefits:

It is not the responsibility of Impressions Pediatric Therapy to quote your insurance benefits. It is your responsibility to know and understand your benefits and address with your insurance company, any questions you may have pertaining to your benefits. Impressions Pediatric Therapy does contact your insurance company for a quote of benefits but this is not a guarantee of payment or coverage. We are not party to your contract or changes within that contract. We will not become involved in disputes between you and your insurance company regarding deductibles, copayments, covered charges, "usual and customary" charges, etc. other than to supply factual information as necessary.

Filing Insurance:

As a courtesy, Impressions Pediatric Therapy will file a claim to your primary insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. As stated earlier, your insurance policy is a contract between you and your insurance company. Impressions Pediatric Therapy will call on any unpaid claim(s) at least every 30 days. The family should call at least monthly to be sure claims are received and being processed. After 60 days, Impressions Pediatric Therapy will inform patients of unpaid claims. After 90 days without payment, the family will be responsible to begin paying on their account balance and private pay future appointments in order to remain on the treatment schedule. If a claim has been denied and is going through the appeals process, the family must begin paying on the balance and private paying new treatment sessions. As the client, you agree that if you default on any balance owed to Impressions Pediatric Therapy and it becomes necessary for Impressions Pediatric Therapy to engage the services of an attorney, collection agency or other lawful method of collection, you, the client, will pay the original balance owed and reimburse Impressions Pediatric Therapy for all costs incurred by the collection of said debt.

Copays, deductibles and coinsurance:

All copays are due at the time services are rendered. If your policy has a deducible, that has not been met, we collect a $50.00 payment at each appointment until the first Explanation of Benefits (EOB) is received from your insurance company. Any balance they have left for that date, you will have to pay at your next appointment. Any deducible and/or coinsurance amount is due upon receipt of the EOB in our office, at your appointment. For your convenience, we accept Visa, MasterCard and Discover in the office and over the phone. We can also keep your credit card on file.

I give my consent to any appropriate and medically necessary procedures, medication, services or therapies that would be included in the treatment as required by the primary care physician or supervised staff for the above named person.
I understand and acknowledge that I am financially responsible for all charges incurred during treatment at Impressions Pediatric Therapy, whether or not paid by insurance, rendered for the above named person.

The adult accompanying the patient is responsible for payment, for that day. We do not get involved in custody or other financial arrangements between parents. We will provide a receipt, if needed, so you can collect from another party.

Parent/Guardian Signature _____ **Date** _____

Print Name _____

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AUTHORIZATION TO USE AND DISCLOSE PATIENT INFORMATION

I am completing this form to allow the use and sharing or protected health information about:

Patient Name: _____ **Date of Birth:** _____

I authorize disclosure of my child's protected health information only in the specific manner, for the named reason, and to the specific individual(s) described below:

Please release information to:
Impressions Pediatric Therapy
7500 Marlboro Pike, Suite A,
Forestville, MD 20747

I want information released from:
Impressions Pediatric Therapy
7500 Marlboro Pike, Suite A,
Forestville, MD 20747

From: _____
_____
_____
_____
_____

To: _____
_____
_____
_____
_____

I authorize Impressions Pediatric Therapy to disclose the following information:

- ☐ All the below
- ☐ Evaluation Report
- ☐ Treatment session notes
- ☐ Billing records
- ☐ Complete copy of the medical record
- ☐ Other: _____
_____
_____

I understand and agree that this authorization will be valid and in effect for 12 months after completing this form. I understand that after that date, no more of this information can be used or released by Impressions Pediatric Therapy, unless I sign a new authorization form. I can revoke consent at any time, provided that the revocation is in writing.

Signature: _____ **Date:** _____

Relationship to the patient: _____

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HIPAA COMPLIANCE

Patient Name:	ID#:

I have received the Organized Health Care Arrangement (OHCA) Joint Notice of Privacy Practices and consent to the OHCAs use and disclosure of protected health information for the purposes as stated in the HIPAA JOINT NOTIFICATION OF PRIVACY PRACTICES. I understand the company members of the OHCA create and maintain health records and other information describing among other things, my health history, symptoms, examination, test results, diagnosis, treatment, and any plans for future care or treatment.

I have been provided with a Joint Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior so signing the consent. I understand that the OHCA reserves the right to change their Notice and practices prior to implementation and will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my protected health information for directory purposes. I understand that I have the right to request restriction as to how my health information may be used or disclosed to carryout treatment, payment, or healthcare operations. The organization is not required to agree to the restrictions requested. By signing this form, I consent and authorize the OHCA to disclose treatment records, assessment reports, progress notes and any other information necessary to the patient's school, physician, and/or any other person or entity that would assist in patient's speech, occupational and/or physical therapy program, payment and health care operation. I have the right to revoke this consent, in writing, except where disclosures have already been made on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have had the right to request that the use of my Protected Health Information, which is used or disclosed for purposes of treatment, payment, or health care operations, be restricted. I also understand that the Practice and I must agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information, which have been previously agreed upon.

Can we contact other family members or other individuals about the patient's general information & diagnosis?	Yes	No

If yes, please list whom we may inform about the patient's general information and diagnosis (including treatment, payment and health care operations):

Name:	Phone:	Name:	Phone:

Can we contact family members or other individuals, about the patient's medical condition only in an emergency?	Yes	No

If yes, please list name & phone:

Name:	Phone:	Name:	Phone:

Can we contact you via telephone number?	Yes	No

If yes, please provide number where we can call about the patient's appointments, test results or additional health information

Home:	Alternate Phone:

The undersigned certifies that they have read the foregoing, received a copy thereof, and is the patient or patient's legal representative to execute the above and accept its terms.

Signature of Patient, Parent or Legal Guardian	Date

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NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Patient Name: _____ **Date of Birth:** _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights has been violated, and that no retaliatory actions will be used against me in the event of such complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ **Date:** _____

Relationship to the patient : _____

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REIMBURSEMENT POLICY

The family is responsible to call their insurance company and be aware of their benefits. They are responsible to pay out of pocket fees at the time of service. Families need to keep track of the number of visits or when pre-certification is necessary. The number of visits and the payment of all claims is the responsibility of the family and not Impressions Pediatric Therapy.

Impressions Pediatric Therapy will call your insurance company, in addition to your call, to verify benefits. This is not proof of insurance payment! We also track the number of visits, but it is not our responsibility.

Impressions Pediatric Therapy, as a benefit to our clients, will submit claims to your insurance. This again is not our responsibility, but it being provided as a benefit to you.

Unpaid claims are called on Impressions Pediatric Therapy at least every 30 days.

Families should call at least monthly to be sure claims are received and being processed.

After 60 days, Impressions Pediatric Therapy will inform patients of unpaid claims.

After 90 days without payment, the family will be responsible to begin paying on their account balance and private pay future appointments in order to remain on the treatment schedule.

If a claim has been denied and is going through the appeals process, the family must begin paying on the balance and private paying new treatment sessions.

Much of this can be avoided by knowing your policy and following up on your claims. The bills are ultimately your responsibility. Impressions Pediatric Therapy is only required, once treatment is provided, to give you the information to get reimbursed from your insurance company. Submitting the claims is not our responsibility, but a benefit to you.

Please help us to keep our costs down and to continue to provide the best quality care possible.

Thank you,
- Impressions Pediatric Therapy

Signature of Parent/Guardian: _____ Date: _____

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CANCELLATION POLICY

Patient Name:	ID#:

Our greatest desire is to deliver our patient's the highest level of care available in order to maximize the benefits of therapy. Consistent attendance demonstrates patient commitment and leads to better potential for patient progress. With your help this can be accomplished.

Our payer sources are requesting daily progress notes as part of the review process for authorization of payment for therapy sessions. All absences are noted and require a reason for the cancellation to be noted. Excused absences include patient illness with doctor's note or note from the parent indicating the reason for cancellation. Extenuating circumstances of absences will be considered. Numerous absences or no shows may result in lack of child's progress in therapy.

Impressions Pediatric Therapy will enforce the attendance policy for clients who do not show or fail to cancel a therapy session with at least 24 hours prior notice, a $50 no show fee will be required. In order to avoid being discharged from the therapy program your child will need to maintain an 85% attendance rate. Notifications of vacations or family obligations are requested at least two weeks prior to the expected absence, to facilitate rescheduling appointment(s).

Same Day Cancellation = Patient has not given 24 hours or more notice.
No Show = Patient has not given 24 hour notice or has not called to cancel.

Rescheduling Appointments

Every attempt should be made to reschedule unattended therapy sessions. Rescheduled sessions may occur with the patient's therapist or other therapists. If your therapist is ill or on vacation, Impressions Pediatric Therapy will provide a substitute therapist to ensure continuation of services. We will make every effort to schedule the therapist at your regularly scheduled appointment time. If this cannot occur, Impressions Pediatric Therapy will provide an alternate appointment time.

Saturday Appointments(If applicable to your location)

Saturday appointments were made available in order to meet the needs of our patients who are not able to make therapy sessions during the week. There continues to be a growing need for Saturday appointments. Due to this growing need on Saturdays, it would not be fair to hold open appointments for patients who do not show or frequently cancel. Therefore, Impressions Pediatric Therapy's policy for Saturday appointments is:

A patient will be removed from the Saturday schedule after one (1) "No Show".

Thank you for the opportunity to work with you, or your child. If you have any questions or concerns, please call and speak to the Office Manager or Directors of Rehabilitation assigned to your location.

Signature of Patient, Parent or Legal Guardian	Date