Chicago Pediatric Orthotics

Patient Registration Form

Today's Date: _____

Patient Information

Patient's name: _____ Birthdate: _____

.

Mailing Address: _____

City:_____State_____ZIP Code_____

Parents Cell Phone: _____

(I give permission for Chicago Pediatric Orthotics to call this number and provide information regarding my child's appointments or care.) ☐ YES ☐ NO

Pediatrician's name and location: _____

Name of person who referred you to our office? _____

(ie. Specialty MD, therapist, friend, etc).

Parent/Guardian Information

Parent name: _____

Mailing Address (if different than patient's)_____

Employer: _____ Occupation: _____

Preferred Language: _____

Primary Medical Insurance (Please provide insurance card(s) to be photocopied).

Policy Holder Date of Birth: _____ Patient's relationship to policy holder: _____

Secondary Medical Insurance (Please provide insurance card to be photocopied.)

Policy Holder Date of Birth: _____ Patient's relationship to policy holder: _____

I certify that I have read and agree to PR Orthotics & OT (dba Chicago Pediatric Orthotics) (CPO) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to CPO all money to which I am entitled for medical expenses related to the services performed, but not to exceed my indebtedness to CPO. I authorize CPO to release any medical information to my insurance carrier or third-party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency and I will be responsible for the balance, late-fees and all costs associated with collections. A $30.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from PRO by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

Signature of Responsible Party : _____

Printed Name: _____ **Date:** _____

Chicago Pediatric Orthotics

HIPAA Notice & Consent to Treat

Patient Name: _____ **Today's Date:** _____

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

By signing this form, you acknowledge that you have been offered a copy for review of PR Orthotics & OT (dba Chicago Pediatric Orthotics), Notice of Privacy Practices which is prominently displayed in the clinic and available on our website. This Notice of Privacy Practices provides information about how we may use and disclose your protected health information. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice and if you have any questions about our Notice of Privacy Practices, please contact our Privacy Officer at (224)470-8550.

x_____ Date_____

Signature of Patient or Responsible Party

CONSENT TO TREAT & AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS

I hereby authorize Chicago Pediatric Orthotics, LLC, (CPO) through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my physician and orthotist/therapist in the treatment of my child's condition. I further authorize CPO to furnish the appropriate agencies, for the purpose of billing, any information acquired during the course of my child's treatment. I am assigning my benefits to CPO, for the services in which my child receives and authorize my insurance carrier to make payments to CPO on my behalf. CPO reserves the right to seek reimbursement from any and all of your insurers regardless of whether you provide us with their contact information, unless you instruct us to bill you directly. I understand that I will be responsible for paying in full any required copayment, deductible or non-covered items. All records released require an administrative and copying fee paid to CPO before they are released, regardless of requestor. CPO is HIPAA compliant regarding information sharing policies.

By signing this document, I acknowledge that I have read, understand and agree that the information contained in this document including insurance benefits and any information I have presented to verify my own identity including my state issued driver's license, state issued photo identification card or my passport, and if applicable any information used to verify the identity of a minor beneficiary is current, correct and complete to the best of my knowledge. I agree to the financial terms stated above.

I further understand and acknowledge that PRO may lease or license real estate, equipment or other personal property (collectively "Leased Property") from third parties to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. In consideration of being permitted to make use of and/or have access to the Leased Property, I do hereby, on behalf of myself, on behalf of any minor or other person for whom I have requested such evaluation and treatment procedures ("Minor"), on behalf of my heirs, successors and assigns, and on behalf of such Minor's heirs, successors and assigns release and forever discharge any and all direct or beneficial owners of the Leased Property and their respective successors, related entities, directors, officers, employees, and agents (collectively, "Releasees") from, and hereby waive and release, any and all claims, demands, actions, and causes of action whatsoever arising out of or in any way related to any loss, damage, or injury, including death, that may be sustained by me and/or such Minor in, on, upon, in connection with or while making use of the Lease Property, regardless of whether any such loss, damage, or injury is caused by the active or passive negligence of the Releasees or otherwise and regardless of whether any such liability arises in tort, contract, strict liability or otherwise, to the fullest extent allowed by law.

Signature of Patient or Guardian _____ **Date** _____

Chicago Pediatric Orthotics

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. **Uses And Disclosures We May Make Without Written Authorization**. We may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment. **We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.**

Payment. **We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain payment for treatment.**

Healthcare Operations. **We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.**

Other Uses or Disclosures. **We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:**

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. **Disclosures We May Make Unless You Object.** Unless you instruct us otherwise, we may disclose your information as described below.

- To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.

3. **Uses and Disclosures With Your Written Authorization**. Other uses and disclosures not described in this Notice will be made only with your written authorization, including for most marketing purposes. You may revoke your authorization by submitting a written notice to the Director identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. **Your Rights Concerning Your Protected Health Information.** You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.

- We normally contact you by telephone, mail at your home address and possibly by e-mail if you have given your e-mail address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.

- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.

- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.

- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.

- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. Changes To This Notice. We reserve the right to change the terms of this Notice at anytime, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our Privacy Officer.

6. Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. Contact Information. If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

Privacy Officer:	**Patricia Rogel**
Phone:	**224-470-8550**
Address:	**4711 Golf Road**
	Suite 525
	Skokie, IL 60076
E-mail:	**progel@chicagopediatricorthotics.com**

8. Effective Date: October 1, 2017.

Chicago Pediatric Orthotics

PHOTO RELEASE

Patient's Name: _____
Last First Middle Ini.

Parent/Guardian Name: _____
Last First Middle Ini.

Home Address: _____

Parent Cell Phone: _____ **Patient's Date of Birth:** _____

INFORMATION AUTHORIZED TO BE USED AND DISCLOSED: I authorize PR Orthotics & OT (DBA Chicago Pediatric Orthotics)("the Company") and others it may authorize to photograph and/or film the patient pursuant to this Authorization. I also authorize the Company to use and disclose the photographs or film and the patient's likeness, identity, statements and information about the patient's health, payment and treatment experience at the Company in any print, broadcast, electronic or other media and in marketing materials pursuant to this Authorization.

TERM: This Authorization will be effective for twenty five (25) years from the date signed unless I submit a written notice of revocation to the Company at the address below. The revocation will be effective immediately upon receipt, except that the revocation will not have any effect on any action taken before receipt of my written notice of revocation.

PURPOSES AND RECIPIENTS: The information identified above may be used or disclosed under this Authorization for

☐ YES ☐ NO fabrication of custom orthoses

☐ YES ☐ NO submission to insurance companies as needed

☐ YES ☐ NO for publicity and marketing

I understand that once the Company discloses information about the patient, they cannot guarantee that the recipients will not redisclose the information to a third party. Further, the recipients may not be required to abide by this Authorization or applicable federal and Illinois law governing the use and disclosure of patient information. I understand that the images may be used for marketing purposes on social media, company websites, promotional materials, and professional presentations.

I understand that I may refuse to sign or may revoke this Authorization at any time for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of the patient's treatment from the Company.

I also release, discharge, and agree to hold the Company harmless from any and all claims of any kind which I, my heirs, executors, and assigns may have arisen out of or in connection with the Company's use of the patient's name, likeness, identity, words or treatment experience pursuant to this Authorization.

I may contact Chicago Pediatric Orthotics, LLC at any time care of Patricia Rogel, Director, 4711 Golf Road, Suite 525, Skokie, IL 60076-1224. Or I can call 224-470-8550, if I have any questions about this Authorization or wish to revoke it.

I have read and understand the terms of this Authorization and had an opportunity to ask questions about the use and disclosure of information about the patient. By my signature, I authorize the uses and disclosures of information about the patient as described above.

_____ _____ _____
Signature of Parent or other Personal Representative (or Patient if of legal age) | Relationship to Patient | Date of Signature

Chicago Pediatric Orthotics

Consent to Communicate via E-mail

Email is a very popular and convenient way to communicate for many people, so in a modification to the HIPAA act, the federal government provided guidance on email and HIPAA. The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website: http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

By signing, you clearly understand that by sending or receiving unencrypted email there is a risk that the information could be read by a third party. PR Orthotics & OT LLC, DBA Chicago Pediatric Orthotics, LLC, (hereafter 'CPO') is NOT responsible for unauthorized access of protected health information while in transmission to you based on this request. Further, CPO, is NOT responsible for safeguarding information once delivered to you. By signing below, you are confirming that e-mail communications are acceptable to you.

By signing you also give Chicago Pediatric Orthotics permission to communicate via un-encrypted email with your referring physician, therapist (PT,OT,DT, SLP), direct care providers and insurance company, as needed for optimum care. It also gives them permission to respond to our emails to them _____
Initial here

I understand that authorized personnel from CPO may communicate with me regarding scheduling, treatment being provided, educational information including new letters as it relates to health-related services available at CPO or alternative treatments, locations, or providers. I hereby authorize CPO, through its appropriate personnel, to communicate with me regarding scheduling, treatment and billing and payment for services rendered on my child's_behalf.

Option 1 – Allow unencrypted email. I understand the risks of unencrypted email and hereby give permission to Chicago Pediatric Orthotics to send me personal health information via unencrypted email.

Parent e-mail address: _____

_____ _____

Signature of parent OR Date

Option 2 – Do not allow email communications.

_____ _____

Signature of parent Date

Chicago Pediatric Orthotics

Financial Policy: Please read entirely.

Please contact your insurance provider to determine if you have any remaining deductible for the calendar year and if you have a copay for durable medical equipment. These costs are the parent's responsibility.

This policy also includes financial responsibility, which includes paying your copay and/or deductible once the insurance claim has been processed. Payments may be made with cash, check, bank transfer, HSA card or credit card. Please provide us with accurate and complete information concerning your child's insurance. You have assigned healthcare benefits to the company, for the services your child receives and do authorize your insurance carrier to make payments to the company on your behalf. You understand that you are responsible for paying in full any required copayment, deductible, co-insurance or non-covered items. A final statement/bill will be sent when insurance explanation of benefits (EOB) is received. You may have additional financial responsibility once the EOB arrives. Late fees will be applied when payment is not made within 30 days of receipt of our statement.

Chicago Pediatric Orthotics is committed to serving our patients with professionalism and caring and from our patients we expect the same commitment. This includes being on time for your appointment and calling to cancel an appointment 24 hours in advance. **If you do not call to cancel, there will be a $50 missed appointment fee. Text reminders will be sent to you for appointments.**

If you do not return to pick up your child's device as scheduled, we will be unable to submit to insurance. Therefore, you will be responsible for the full cost of the device without your insurance provider's discount.

If your account is 60 days past due it will be transferred to a collection agency. All debt collection expenses will be added to the balance and be the responsibility of the patient's parent or guardian.

A 3% credit card convenience fee will be added to your payment if paying by credit card. There is no fee for personal check, HSA, FSA, bank transfer or debit cards. We are required by Visa, Mastercard, Discover, and American Express to notify you that we are adding this fee to all credit card payments. As required under state law, this surcharge is not greater than the amount charged to us by our credit card processors.

_____ _____

Signature of parent Date