THE PEDIATRIC MOVEMENT CENTER

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PATIENT INFORMATION

Last Name_______________________________First_____________________________D.O.B____________________Sex: M / F

Home Address___________________________City__________________State__________Zip____________Phone_____________________

Diagnoses______________________________________ Legal Guardian(s)____

Is English the patient's primary language? Yes/ No If not please specify____

PARENT INFORMATION

Mother's last name____________________________First_____________________________Cell Phone________________________________

Address____City____State___________

Father's last name_____________________________First_____________________________Cell Phone_______________________________

Address____City____State__________

E-Mail Address___________________________________ Is English your primary language? Yes/ No If not please specify__________________

EMERGENCY CONTACT

Last name_________________________________First__________________________________ Relationship to patient_________________

Phone_______________________________Address_________________________________City______________________State_________

REFERRING PHYSICIAN

Physician Name____

Do you have a prescription: YES / NO Would you like us to assist you in attaining a prescription? YES / NO

Address________________________________City___________________State________Telephone Number__________________________

INSURANCE HOLDER/GUARANTOR INFORMATION

Insurance holder/Guarantor Last Name____First_____________________________________

D.O.B.____________________________ Social Security Number____________________________ Phone____________________________

Employer Address_______________________________City______________________State___________Phone______________________

Insurance Name _______________________________ Policy Number ______________________Group Number_______________________

Insurance Phone____________________________Address______________________________City___________________State___________

**Please include a copy of your insurance card (front and back) if you would like us to verify benefits prior to your initial evaluation

PAST MEDICAL HISTORY

Recent Hospitalization or Surgery and Date____

Current Medications____

Allergies____

SOCIAL

What school does your child attend____Grade______________________

What are your child's strengths____

Weaknesses____

Has your child received therapy services in the past or are they currently receiving therapy? If so, where?

____

____

Do you have any specific concerns you would like to share with us regarding your child?

____

____

What goals would you like to see your child accomplish?

____

____

Please list any behavioral issues:

____

____

Are there any behavioral strategies being used?

____

____

Please list any additional questions or concerns you may have here:

____

____

____

____

I give permission for The Pediatric Movement Center to treat my child, ____

Parent/Guardian Print____

Parent/Guardian Signature____Date______________________________

O(301) 739-5437 :: F (301) 739-7453 :: info@pmchag.com :: www.pmchag.com
1045 Maryland Ave, Hagerstown, MD

PATIENT AUTHORIZATION

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for The Pediatric Movement Center. In addition, I hereby consent to the use and disclosure of my child's personal health information for the purposes of treatment, payment, and health care operations.

Initial:______________

Release of Information & Consent for Treatment: All information provided herein is true and correct.

I am aware of my child's diagnosis and wish him/her to receive treatment from the therapists employed by The Pediatric Movement Center. I permit its employees and all other persons caring for my child to treat him/her in ways they judge are beneficial to him/her. I understand that this care can include evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

Initial:______________

I give permission to The Pediatric Movement Center to release information, verbal and written contained in my child's medical record, and other related information, to my insurance company, physician, case manager, attorney, employer, school, related health care provider, assignees and/or beneficiaries and all other related persons to my child's treatment or payment for services provided.

Initial:______________

I give my permission for The Pediatric Movement Center to use photographs and video taken of myself or my minor child during therapy sessions for educational, informational and promotional materials.

Initial:______________

I authorize The Pediatric Movement Center to obtain medical records and/or professional information from my child's physician or other medical professional as it relates to my child's treatment.

Initial:______________

I understand that The Pediatric Movement Center also serves as a training and research facility and at times other therapists and students may be observing, handling, or have access to my child's medical information.

Initial:______________

Payment Guarantee

I agree to pay The Pediatric Movement Center for the services provided to my child or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services, I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

Initial:______________

The Benefit Verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services.

Initial:______________

Parent/Guardian signature:____Date:____________________

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FINANCIAL RESPONSIBILITY

I understand that although my insurance may cover a portion of the cost of the therapy services I receive at The Pediatric Movement Center, I am ultimately responsible for the complete payment of all charges**. Our staff verifies your insurance benefits prior to the onset of services as a courtesy to you. Although we strive to obtain the most accurate information possible, the quoted benefits from your insurance company are not a guarantee of payment. Should you need detailed information about your coverage, please contact your insurance company directly.

Payment in full is required for all services at the time they are rendered unless The Pediatric Movement Center is billing my pre-verified insurance. If The Pediatric Movement Center is billing my insurance I will pay any unmet deductible, non-covered services, co-insurance, or co-payments at the time of service.

PAYMENTS PENDING INSURANCE CONSENT

I understand that my private insurance may not cover the services my child receives. Although The Pediatric Movement Center takes every attempt to prevent this, I am responsible for all services charged at the private pay rate**.

INSUFFICIENT FUNDS

I understand that if my account is past due 30 days, The Pediatric Movement Center will bill the credit card below to cover my outstanding balance and a $20.00 service fee will be charged to me on all checks returned for non- sufficient funds. In the event my account is turned over to a collection agency, a collection fee of 25% of the outstanding balance will be added to my account to cover the cost of collection.

All clients must fill-out the credit card information. If you would also like to bill this credit card automatically at the time of service from your unmet deductible, non-covered services, co-insurance, or co-payments, please check the box, sign, and date. **Private pay clients must choose "YES" or discuss directly with the on-site manager.**

The Pediatric Movement Center accepts payment in the form of cash, check, or credit card.

____ Yes, please bill my credit card automatically at the time of rendered services.

____ No, I would prefer a bill be sent to my home monthly.

The credit card form must be completed by all clients regardless of billing cycle status. Credit card information is required for services rendered and pending insurance consent and for other services and fees charged without a valid or timely payment by the client.

CARD TYPE VISA______________MASTERCARD______________AMEX______________FLEX SPENDING______________

CARD NUMBER______________________________________EXP DATE_____/______VERIFICATION CODE__________

BILLING ADDRESS_________________________________CITY________________________STATE_____ZIP_________

NAME ON THE CARD____

AUTHORIZED SIGNATURE____

I UNDERSTAND AND AGREE TO THE TERMS OF THE FINANCIAL RESPONSIBILITY POLICY

Authorized Signature: ____________________________________ Date: ________________

***See Private Pay Therapy Services Fee Schedule and Payment Policies.*

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THERAPY TERMS OF SERVICE AGREEMENT

COMMUNICATION AND CORRESPONDENCE

Please circle which methods of communication are acceptable for discussing treatment appointments and other treatment related information:

Cell Phone/Voicemail   Text Message   Email   Home Phone/Voicemail

I agree to receive communication from The Pediatric Movement Center through the above circled methods. I understand I am responsible for additional data charges imposed by my service provider and acknowledge The Pediatric Movement Center is not liable for any

PHOTO RELEASE - OPTIONAL:

This signed paper indicates that I **AGREE**________or **DISAGREE**_______to have my son/daughter video-taped and/or photographed. I give my permission for these videos or photos to be viewed by others as an educational tool. I further **AGREE**________or **DISAGREE**_______to have my son/daughter's photographs (pictures, videos, and treatment progress), to be displayed on my therapists' website, social media or used in publications related to The Pediatric Movement Center in order to share my child's accomplishments and demonstrate the work done at their clinic as indicated by my signature below.

NO SHOW AND CANCELLATION

The Pediatric Movement Center strives to provide quality treatment services for your child. Regular attendance is necessary to establish a positive treatment routine and to ensure progress is made toward your child's goals. We want your family to view your child's treatment appointment as a regularly scheduled event.

In fairness to children currently waiting for services, please be advised of our attendance policy.

CANCELLATIONS	ACTION/FEES
24 hour notice required for a cancellation	No Fee
A cancellation less than the required 24 hour notice*	$25.00
3 cancellations in a row	Placed on waiting list
NO-SHOW	**ACTION/FEES**
No show appointment	$35.00
2 no show appointments in 1 month	Placed on waiting list
3 no show appointments	Discharged

*We understand that extenuating circumstances may occur and will be placed under consideration with your therapy team and The Pediatric Movement Center administration. Implementation of any fee or action is at the discretion of your therapist.

Thank you for allowing The Pediatric Movement Center to serve the treatment needs of your child.

By signing below, I, the parent/guardian of ____agree to the above stated therapy services agreement.

Parent or Legal Guardian's Signature:____Date:____________

SICKNESS AND HYGIENE POLICY

The Pediatric Movement Center is a multi-disciplinary pediatric therapy clinic. Due to the medical needs of our clients and in consideration of health of our staff/therapist, we require that parents/caregivers cancel treatment sessions for the following reasons:

- Illness symptoms within the last 24 hours
- Fever: child must be fever free (no temperature greater than 101 degrees) for the last 24 hours
- Diarrhea: Five or more loose, watery stools within 24 hours
- Vomiting within the last 24 hours
- Sore throat or difficulty swallowing
- Rash or spots on skin; ringworm infection
- Severe itching
- Mouth sores
- Eye discharge
- Unusual nasal discharge
- Uncontrolled coughing
- Difficulty breathing, wheezing
- Wounds that are not properly covered

SOILED CLOTHING

If you child has child has urinated or defecated in their clothing during a treatment session and does not have a proper change of clothes, the session will be ended at that time.

HEAD LICE

The Pediatric Movement Center supports the Head Lice Policy of the American Association of Pediatrics. If you know your child has live crawling head lice, begin a treatment to kill live lice before coming to therapy. We advise seeking professional care of lice and nit removal. Child must be cleared of nits and lice prior to returning to therapy clinic to support containment of lice and reduce risk of spreading to others and on therapy equipment.

Please sign to acknowledge and accept the terms of the above sickness and hygiene policy.

Parent/Guardian Signature:____Date:____________________

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Outpatient Therapy Prescription Form

Patient Name:____ DOB:______________

Diagnosis:____

Surgical Procedure:____ Onset Date:__________

Precautions:____

☐ PHYSICAL THERAPY

☐ Evaluate and Treat

☐ Other ____

☐ OCCUPATIONAL THERAPY

☐ Evaluate and Treat

☐ Other____

☐ SPEECH THERAPY

☐ Evaluate and Treat

☐ Other____

☐ ADAPTIVE EQUIPMENT EVALUATION

☐ Equipment Needs____

Referring Physician Signature________________________________ Phone #_________________

Print Name____ Fax #____________________

Prescription expires in 90 days

Please fill out and return with a copy of demographics and insurance cards to The Pediatric Movement Center:

info@pmchag.com :: F (301) 739 - 7453

To schedule an evaluation please call (301) 739 – 5437