

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 _____

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: _____

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**. I agree to pay the Pediatric Movement Center for all charges that insurance does not pay. Our staff offers to verify 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 or upon receipt of an invoice. The Pediatric Movement Center accepts payment in the form of cash, check, or credit card.

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**.

OUTSTANDING BALANCES

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. 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.

INTEREST

The undersigned agree to pay the Pediatric Movement Center interest in the amount of 18% per annum (1.5% per month) on any balance which is unpaid after 30 days from the date of invoice

ATTORNEY FEES

The undersigned agree to pay the Pediatric Movement Center attorney fees in the amount of 15% of the amount due to the Pediatric Movement Center pursuant to this contract, or a greater amount of reasonable attorney fees proven at trial in the event the undersigned's account is placed in the hands of an attorney for collection, whether suit is filed or not, together with court costs and cost of collection

AUTOMATIC PAYMENTS

If you would also like to bill this credit card automatically at the time of service for your non-covered services or co-payments, please check on the line below. Private pay clients must choose "YES" or discuss directly with the on-site manager.

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

By signing below I authorize the Pediatric Movement Center to charge my credit card for any services provided by the Pediatric Movement Center. This Authorization shall not expire until three years after the date of last service provided by the Pediatric Movement Center

REQUIRED CREDIT CARD INFORMATION: 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 (payment made within 30 days).

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.

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/FEEES
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/FEEES
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 your 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: _____



KIDSTRONG :: KIDSENSORY :: KIDSUCCESS

RELEASE FORM

Child Name(s) _____ Today's Date _____

Parent or Guardian _____

Please note that it is PMC policy that for all Open Play classes, programs, and gatherings that parents and/or legal guardians must accompany and take responsibility for the safety of all children in their charge.

I (Class participant/parent/legal guardian) agree that if I (or my child) engage in any physical exercise or activity at the Pediatric Movement Center, I do so at my own risk. This includes, without limitation, my use of the facility, equipment, parking area, or sidewalk and my participation in any activity, class, program or instruction now or in the future made available. The Pediatric Movement Center will be enforcing particular class rules, equipment usage rules, and personal discipline to reduce risks that exist.

Initial: _____

I agree that I am voluntarily participating in these activities and using the equipment and facilities and assuming all risk of injury or my contraction of any illness or medical condition that might result there from, or any damage, loss or theft of any personal property.

Initial: _____

I acknowledge that I have carefully read this waiver and release and fully understand that it is a release of all liability, in addition, I, for myself and on behalf of my child hereby release and hold harmless the Pediatric Movement Center their officials, employees, other participants, sponsors, advertisers, owners and lessors of premises for any injury incurred from class participation. I do hereby waive any right that I may have, by or on behalf of myself, my spouse, or any child (minor or otherwise), to bring legal action or assert a claim for injury or loss of any kind against us for negligence or arising out of or relating to participation by myself, my spouse or child in any of the activities, or use of the equipment, facilities or services offered by and at the Pediatric Movement center.

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: _____

Please list any allergies or medical conditions we should be aware of

Participant or Guardian Signature _____ Date _____



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 # _____

Date _____

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