



10791 So. 72nd Street, Suite 103
Papillion, Nebraska 68046
402-932-2782
Fax 402-932-2705
www.ptcne.org

Providing the Building Blocks for Success

Welcome to Pediatric Therapy Center, PC!

We appreciate the opportunity to work with you and your child. Please read through and complete all paperwork before your arrival. We ask that you please arrive 15 minutes prior to the start of your appointment. We also ask that siblings not attend the evaluation appointment due to the length of the appointment and so as not to distract from any testing that may need to be administered.

Use the checklist below to ensure all necessary forms have been completed and reviewed. After completion of this packet, please sign below and return to Pediatric Therapy Center at the time of your evaluation.

Thank you for your confidence in Pediatric Therapy Center and we look forward to working with you and your family.

This packet includes the following:

- General Info, School Info, Development & General Health, Milestones (Pages 2-3)
- Food Permission Info, Video & Picture Release, & Consent to Release Info (Page 4)
- Attendance Policy & Drop Off Policy (Page 5) **(For your records)**
- Parent Attendance, Sick Policy, & Financial Policy (Pages 6-7) **(For your records)**
- Notice of Privacy Policies and Practices (Page 8) **(For your records)**

My signature below is confirmation I have read and received all necessary paperwork and I agree to all terms and conditions. I further acknowledge I have informed Pediatric Therapy Center of all necessary information and have answered all questions truthfully and to the best of my ability.

Child's Name

Parent/Guardian Signature

Date



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General Information

Child's Name: _____ Date of Birth: _____

Child's Address: _____ City/State/Zip: _____

Parent/Guardian Names: _____

Home Phone: _____ Parent Email: _____

Work Phone: Mom: _____ Dad: _____

Cell Phone: Mom: _____ Dad: _____

Emergency Contact & Relationship: _____ Phone: _____

Primary Care Physician: _____ Clinic Name: _____

How did you hear about us? _____

School Information

Name of School: _____ Current Grade: _____

Teachers Name: _____ Academic Concerns: _____

Does your child currently receive school based services? YES NO If so, please provide types of therapy and frequency:

Development and General Health

Was your child born before 37 weeks?	NO	YES. Please specify:
Did your child spend time in the NICU?	NO	YES. Please specify:
Were there any complications, illnesses, or stress during pregnancy?	NO	YES. Please specify:



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Did your child require special treatment after birth? (i.e oxygen, jaundice, etc.)	NO	YES. Please specify:
Has your child received any therapy services in the past?	NO	YES. Please specify:
Does your child have a medical diagnosis?	NO	YES. Please specify:
Does your child currently take any medications?	NO	YES. Please specify:
Has your child experienced any major injuries or hospitalizations?	NO	YES. Please specify:
Has your child had problems with his/her ears or hearing?	NO	YES. Please specify:
Does your child wear glasses?	NO	YES.
Has your child had or is he/she currently scheduled for any additional tests regarding their chief complaint(s)? (MRI, swallow study, hearing test, etc)	NO	YES. Please specify:
Does your child have a history of seizures?	NO	YES. Please comment:

Milestones

(Give approximate ages if remembered, or comment on anything unusual)

Rolled over _____ Sat alone _____
 Crawled _____ Walked _____
 Chewed food _____ Drank from a cup _____
 Said words _____ Said sentences _____
 Finger fed _____ Used utensils _____



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Food Permission/Dietary Information

Please list any allergies your child may have, including food, non-food, and/or latex:

Please complete the following to allow your child to participate in snack activities.

_____ My child may participate in snacks and has no diet restrictions.

_____ My child may participate in snacks if diet restrictions are observed.

Diet Restrictions: _____

_____ My child may participate in snacks; however, I will provide his/her snack.

_____ My child should **not** participate in snack time.

Please list the food(s) your child is motivated to eat: _____

Video and Picture Release

_____ I give permission for my child's picture/video to be used by Pediatric Therapy Center, P.C. for the purpose of training other professionals or paraprofessionals.

_____ I give permission for my child's picture/video to be used by Pediatric Therapy Center, P.C for marketing/publicity.

_____ I do not wish my child's picture/video to be used for any purpose other than training his/her specific clinical team.

Consent to Release/Receive Medical Information

We understand the importance of coordinating and communicating with other persons involved in your child's development. We encourage you to provide us with contact information of other professional(s) working with your child.

I agree to let Pediatric Therapy Center, P.C. share and receive information from other agencies (organizations) about my child so services can be coordinated and optimized for my child's benefit. The following organizations are included in this release:

Medical Professionals: _____

Schools/Teachers: _____

Other: _____

Please Note: PTC therapists are available to meet with your child's educational or treatment team outside of a normal treatment session. These consultations are charged at the rate of an individual session. These include consultations with parents, other professionals and teachers regarding your child's treatment.



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****PLEASE KEEP FOR YOUR RECORDS****

Attendance Policy

Pediatric Therapy Center, P.C. understands there are times when families need to cancel therapy appointments. We request that whenever possible families provide at least 24 hours notice when therapy appointments must be cancelled. Please call the office as soon as you realize that your child will not be able to attend therapy. You may leave a message on voicemail 24 hours a day.

In order to allow us to meet the needs of all the children seen at PTC, we have attendance policies that, if violated, will require us to cancel all previously scheduled appointments. Some possible causes that may require this action include:

1. Missing 3 appointments with less than 24 hours notice in a 60 day period.
2. 5 or more cancellations for any reason in a 60 day period.
3. Arriving more than 5 minutes late to pick up your child from therapy 3 times in a 60 day period.

These attendance issues will result in the following actions:

- Children with regularly scheduled appointments will be removed from any future scheduled times, and will be required to schedule therapy sessions on a weekly basis as appointments are available. This probationary period will last 4 weeks beginning with the date of the first call.
- After this period children may resume regular scheduling including scheduling appointments up to 4 weeks in advance.
- Any additional attendance issues may result in an increased probation/weekly scheduling period or the patient may be discharged from therapy services.

Pediatric Therapy Center reserves the right to discharge any patient from therapy due to attendance issues.

Drop Off Policy

Parents are expected to be on time for arrival and pick up of their children for appointments. Children that arrive 5 or more minutes late for an appointment will be seen or rescheduled as appointments are available. We value the importance of establishing and maintaining home programs for the children that receive therapy. Parental/guardian involvement is the key to success for the child. We request that you be available 10 minutes PRIOR to the end of your child's therapy so the staff may talk with you and educate you on any home programming needs. If you are unavailable 10 minutes prior to the end of the treatment session or arrive late to pick up your child, the staff will not be able to address your home program or questions as they have other children to see.

Parents/guardians may leave the premises of PTC during their child's treatments sessions if we have a cell phone number to reach you. If you do not have a cell phone, we require you remain on the premises.



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Sibling/Parent Attendance Policy

Due to the number of children that are being seen at a given time, it is the policy of PTC that siblings will not be allowed in the gym area during a treatment session. We encourage parental involvement and parents are welcome to attend therapy, however we ask that you sit off to the side to optimize the effectiveness of the session. We have limited space in our gym area and request that only one adult at a time be present in the gym during your child's treatment session. This will allow us to maximize the use of the space that we do have for all of the children being seen.

Sick Policy

In order to maintain the health of the staff and other children please do not bring your child if they have had a fever or experienced symptoms that are contagious within a 24-hour period. If your child shows visible signs of illness, their appointment may be rescheduled at the therapist's discretion.

Financial Policy

Insurance

PTC participates in most insurance plans. PTC will bill the patient's insurance company as a courtesy. Insurance claims will be filed daily by our billing vendor. The patient's insurance company may request patients to supply certain information directly, that is the responsibility of the patient to comply with their request. The patient is directly responsible for the balance of their claim whether or not their insurance company pays the claim. The patient's insurance benefit is a contract between the patient and the insurance carrier; PTC is not a party to that contract. If PTC does not participate in a patient's insurance plan, PTC will grant the patient a 20% discount for balances paid in full at the time of service.

Please make sure we get a copy of your insurance card and/or ID when you arrive at your first visit or if you receive a new card in the mail after your first visit. If you fail to provide this information in a timely manner, you may be responsible for the balance of the claim. Pediatric Therapy Center will file claims with up to two insurances on your behalf; you will be responsible for filing any additional claims. Pediatric Therapy Center will verify your insurance coverage before your initial evaluation and can inform you of your child's benefits. This is not a guarantee of benefits or payment. We also recommend that all families call their insurance company directly to get an explanation of benefits to make sure all information is understood. Some if not all services a patient receives at PTC may be non-covered or not considered reasonable or necessary by insurers. Patients may be billed for such services if applicable.

Referrals

It is the patient's responsibility to get any referral or pre-authorizations prior to the time of their visit or procedure. If the patient is unable to obtain the authorization at the time of their appointment, they will need to be rescheduled.



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Co-payments and Deductible

All co-payments and deductibles must be paid at the time of service. This arrangement is part of the patient's contract with their insurance company. Failure on PTC's staff to not collect co-payments and deductibles from patients can be considered fraud. **If you have an insurance co-payment it will be collected when you sign in at each visit.**

Methods of Payments

PTC accepts payment by cash, check, VISA, MasterCard, Discover, and all Flex Spending Cards associated with one of these major credit cards. A \$35.00 service fee will be added to all checks returned for insufficient funds. If your check is returned, you will be required to pre-pay all future services in full by cash, Visa or MasterCard.

Patient Statements

Unless other arrangements are approved by PTC in writing, the balance of the patient's statement is due and payable when the statement is issued, and is considered past due if not paid within 30 days of issuance.

Nonpayment

If the patient's account is past due 90 days or greater and the balance has not been paid in full or a payment arrangement made, the patient could be sent to collections. Until these balances are paid in full, our therapists will only be able to treat these patients on an emergency basis for a previously treated injury or problem. Any allowed visits will require cash or credit card payment in full at the time of service, unless they have valid insurance. Patients may be terminated due to non-payment.

If a patient has filed bankruptcy in the past, any future visits would need to be paid by cash or credit card if the patient does not have valid insurance. If there is a valid insurance, any co-payments or deductibles would still need to be paid at the time of service.

Divorce

In the case of a divorce or separation, the party responsible for the account balance is the parent authorizing treatment for a child. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Credit Balance Refunds

Pediatric Therapy Center, P.C. will make a good faith effort to capture all accounts which have been overpaid by a patient or insurance carrier and to refund the appropriate party within a reasonable time frame.

Refunds will be issued:

- Quarterly, upon review of the accounts receivable aging detail credit balance report.
- Via company check, payable to the patient or insurance carrier.

Payment Plan

If the patient is a self-pay patient with no valid insurance coverage a 20% discount will be given to balances paid in full at the time of service.



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All patient balances are expected to be paid in full at time of service or 30 days upon receipt of patient statement. If full payment cannot be made a payment plan may be arranged.

In signing the cover sheet of this packet you certify that you have provided Pediatric Therapy Center with the most accurate insurance information available. In addition, you understand that you are financially responsible for all charges whether or not paid by insurance. This also authorizes Pediatric Therapy Center, P.C., to release all information necessary to secure the payment of benefits. All payments will be made directly to Pediatric Therapy Center.

Notice of Privacy Policies and Practices

Pediatric Therapy Center, P.C. (PTC) respects the confidentiality of your child's health information and will protect this information in a responsible and professional manner. We are required by law to maintain privacy of your child's health information and inform you of your right to privacy.

1. You have the right to ask PTC to restrict how we use or disclose your information for payment and healthcare operations. However PTC is not required to agree to a restriction you request.
2. You have the right to request confidential communications of your child's information.
3. You have the right to copy and inspect components of your child's information that PTC obtains.
4. You have the right to request an amendment of your child's records. PTC has the right to deny your request, however we will discuss with you the details of the amendment process.

Authorization to Disclose Medical Information for Insurance and Medical Purposes

Unless notified by the child's guardian, it is the policy of Pediatric Therapy Center, P.C. to release any requested medical information to the insurance company to establish financial coverage of services rendered. Pediatric Therapy Center, P.C. will also send results of evaluations and recommendations to the referring physician for coordination and continuity of care.

Other Releases of Medical Information

Pediatric Therapy Center, P.C. may use or disclose your protected health information (PHI), for treatment, payment, and health care operation purposes with your consent.

Pediatric Therapy Center, P.C.(PTC) may also use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse

If PTC knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare, the law requires such knowledge or suspicion to be reported to the proper authorities.

Judicial or Administrative Proceedings

If you are involved in court proceedings, and a request is made for information about your child's diagnosis or treatment records, such information is privileged under state law and will not be released without the written authorization of you or your legal representative. The privilege does not apply where the evaluation is court ordered.