In Harmony Pediatric Therapy

Information in this form can be shared with:

- ☐ Grow With Me PT
- ☐ Rising Stars Children's Therapy, Inc.
- ☐ Therabeat, Inc.

Please make a check mark next to new information for 2012

Patient Information Form

☐ ***NEW INFORMATION!***

Child's Name **(as appears on insurance card)**: ________________________________ **DOB:** ___________ **Gender: M or F**

Parents' Names: ____

Address: ____**City**________________________**Zip**________________

Please circle preferred method of communication.

Phone Number: _________________________ **Cell Phone Number:** ___________________________

E-mail:____

Diagnosis (if known):____

Primary Physician: ____

Physician's Phone and Address: ____

Referring Physician (if different): ____

Other doctors and specialists who are involved in your child's care:

Name	Specialty	Phone Number

☐ ***NEW INFORMATION!***

Insurance Information:

Primary Insurance:___________________________ Name of Insured:____

Insured SS #:________________ Member ID:___________________________ Group #:_______________________

Claims Address (found on back of card):____

Cust Service #:___________________________________

Secondary Insurance:______________________ Name of Insured:____

Member ID:________________________________ Group #:____

Claims Address (found on back of card):____ Cust Service #:__________

Medicaid Number:_____________________________ Effective Date:____________________________

In Harmony Pediatric Therapy

☐ **NEW INFORMATION!**
Family Background

Mother's Name: ____________________________ DOB: ________ Occupation ______________________________

Father's Name: _____________________________ DOB: ________ Occupation ______________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Languages Spoken at Home (circle primary): ____

Is your child adopted? Y N Adoption Background: ____

What are your priorities in coming to therapy?

____

____

____

Has your child previously received therapy services? ☐ Yes ☐ No

If "Yes", where and when? ____

☐ ***NEW INFORMATION!***
Medical History
At how many weeks was your child born? _______________ Birth weight? _________________

Were there any complications during the pregnancy or delivery? ☐ Yes ☐ No Please describe: _______________

____

Was your child hospitalized after birth? ____

Does your child have any other medical issues? ____

____

Please list any hospitalizations and/or medical procedures your child has received:

____

____

ALLERGIES

Please list all known allergies that your child has.	***Reaction:***
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

In Harmony Pediatric Therapy, Inc.
310 Paper Trail Way, Suite 302, Canton, GA 30115
Phone: 770-345-2804 Fax: 678-827-0927 www.inharmonypediatrictherapy.com

Current medications:

Name	Dosage	Frequency	Reason for medication

Education Information

Is your child currently enrolled in school? ☐ Yes ☐ No

If "Yes", where and days attended:____

Does your child receive any services through the school? ☐ Yes ☐ No

If "Yes", what services? ____

Does your child have a current Individualized Education Plan (IEP) or IFSP? ☐ Yes ☐ No

Date of last review: ______________________________

Social/Emotional History

What are your child's favorite toys/activities?____

____

____

What are your child's favorite songs?____

____

Is your child currently enrolled in any community activities (music class, play groups, Mother's Morning Out Program)?____

____

____

Anything else you would like to tell us about you or your family? ____________________________

____

____

How did you hear about In Harmony Pediatric Therapy? ____________________________

________________________________ ________________________ ______________

Name of Person Completing This Form **Relationship to Child** **Date**

Financial and Insurance Policy Effective 1/1/2012

Thank you for choosing *In Harmony Pediatric Therapy*, a collaboration of providers with Grow With Me Pediatric Physical Therapy, Inc., Rising Stars Children's Therapy, Inc., and Therabeat, Inc. **The above mentioned companies are the companies that will bill your insurance, not *In Harmony Pediatric Therapy*. Please understand this when searching for participating providers in your network and when reading your insurance statements.** The following information explains our billing and financial policy. Please do not hesitate to contact us regarding questions about billing/payments.

RSCT & GWM are in-network providers for BCBS PPO/PAR/HMO plans and RSCT is also in-network with United Healthcare. Claims will be submitted to insurance companies at a reasonable and customary rate. Benefits will be verified prior to the start of therapy. Information obtained from insurance companies is **not always a guarantee of payment**. Families are ultimately responsible for payment for non-covered services. **It is imperative that families are aware of their insurance coverage and their potential responsibilities.** Unless your child has Medicaid, families are responsible for all co-pays, coinsurances, and deductible expenses associated with each date of service. All companies within *In Harmony Pediatric Therapy* accept cash, check, VISA, MASTERCARD, and Discover. There is a $50 fee for all returned checks.

If payment has not been received from the insurance company within 60 days from the date of service, the family will be responsible for the balance. If a family receives a bill that is not paid within 30 days of receipt of invoice, there will be a **10% monthly late fee** added, and services risk being put on hold.

If you do not have insurance coverage for therapy services or opt-out of using your insurance, our billing managers will discuss private payment options with you.

_______________________________________ ___________________________

Parent/Legal Guardian Signature **Date**

Consent to Treat

I, ________________________ consent for In Harmony Pediatric Therapy to provide my child, _______________ with Occupational, Physical, Speech Therapy, and/or Music Therapy services. I consent to care and treatment falling under the practice guideline of the American Occupational Therapy Association (AOTA), American Speech-Language-Hearing Association (ASHA), American Physical Therapy Association (APTA), American Music Therapy Association (AMTA), and the State of Georgia.

I acknowledge that there is always a risk of injury with any therapy involving physical activities and equipment. IHPT is NOT responsible for any injury associated with equipment use when your child is not with a treating therapist. You are responsible for making your therapist aware of any changes to your child's physical or mental condition. IHPT is a teaching facility and supervised students and volunteers may participate in your child's treatment session.

___________________________ _______________________

Parent/Legal Guardian Date

I have read, understand, and agree to the In Harmony Pediatric Therapy, HIPAA Notice of Privacy Practice.

Signature: ____________________________________ **Date:** ____________________

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Permission for Exchange of Medical Information

I authorize In Harmony Pediatric Therapy to release and communicate necessary and pertinent medical information to physicians, case managers, and insurance companies as needed for my child, ______________________________.

Approved information may be given to, received from, and discussed with the following people *directly* related to my child's care:

- ☐ Other Therapists____________________________________
- ☐ School Name: ______________________________________
- ☐ Please list any other/s ____
  ____

Approved information includes **written documents** and/or **verbal discussion.**

____

PARENT/GUARDIAN SIGNATURE DATE

____

PRINTED NAME

Permission for Family to Leave Site During Treatment

I, ____________________________, acknowledge that I am the parent of ________________________.
I understand that while my child is receiving therapy I may leave the premises. However, I understand that I will give to In Harmony Pediatric Therapy a working cell phone number where I can be reached during my absence. In addition, I agree that I will not travel more than **ten miles** from the satellite and will return **15 minutes prior** to the end of the session. I give consent and permission to In Harmony Pediatric Therapy for any additional treatment or transportation that may be needed in the event my child is injured or needs medical attention. I understand that failure to comply with the requirements listed above will result in immediate revocation of this ability. Also, I understand that the ability to continue to leave the premises while my child is in therapy is at the discretion of In Harmony Pediatric Therapy and/or the therapist and may be revoked at any time.

I hereby release In Harmony Pediatric Therapy, and any agents as well as any assignees, from any and all claims for damages related to my leaving the premises during my child's therapy.

Cell Phone Number: ________________________________

_________________________________ _________________________________ ____________

Signature Printed Name Date

____

Secondary Emergency Contact Name & Phone Number

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Consent for Audio/Visual Release

I ___________________________ give permission for __________________________ to be audio or video taped by the therapists at In Harmony Pediatric Therapy. These audio or video taped sessions will be used for education and training purposes only (i.e., clinical supervision, conference presentations). At no time will your child's full name be spoken on the tapes and your child's full identity will remain confidential. These tapes may be maintained in a locked facility.

Signature of parent/guardian: _____________________________________Date:_____/___/_____

Consent of Photograph Release

I ____________________________ give permission for my child ________________________________ to be photographed by the therapists at In Harmony Pediatric Therapy. These photographs will be used for education and training purposes (i.e., clinical supervision, conference presentations), and may be used by In Harmony Pediatric Therapy for advertisement purposes (i.e., brochures, Facebook, Twitter, newspapers).

Signature of parent/guardian: ______________________________________ Date:___/___/_____

Attendance Policy

Your child's progress depends on your family's commitment to therapy. Therefore, attendance at your scheduled therapy appointment is expected.

In Harmony Pediatric Therapy's policy states that we require a 24 hour notice for cancellations. After a one-time courtesy occurrence, a **$25 cancellation fee will be charged for EACH missed therapy appointment. Please note that insurance cannot be billed for this fee and you will be personally responsible for this charge.** We will consider waiving this charge if you are able to **reschedule your missed appointment**.

If you miss three (3) consecutive weeks of therapy or have chronic cancellations, we will discuss other options as we may not be able to hold your slot.

All of our therapists work with medically fragile children and we don't want to carry sickness to other families, infect ourselves, or our own families. Please be respectful and cancel your therapy appointment if your child is sick. You will not be a charged a cancellation fee for sickness and we will work to reschedule your appointment when your child is healthy. The Board of Health considers the following signs to indicate communicable disease/illness: **Vomiting, Fever over 100 degrees, Diarrhea, Sore throat, Rash/Swelling, Red, or running eyes.** Please be sure your child is symptom free for 24 hours before resuming therapy.

Our therapist's time is very valuable and the duration of therapy sessions are catered to your child's needs. Please arrive on time for you appointment and 15 minutes prior to the end of the session.

Parent/Guardian Signature: ______________________________________Date:___________