In Harmony Pediatric Therapy

New Patient Information Form

Child's Name (as appears on insurance card) _____ DOB _____ M or F Date: _____

Parents' Names_____

Address_____City_____Zip_____

Please circle preferred method of communication

Phone Number_____ Cell Phone Number _____

E-mail_____

Emergency Contact (other than person bringing child to therapy)_____

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

Insurance Information

_____I decline use of my insurance and will pay at the time of service

Primary Insurance_____ Name of Insured_____

Insured SS #_____ Member ID_____ Group #_____

Claims Address (found on back of card)_____

Customer Service #_____

Secondary Insurance_____ Name of Insured_____

Member ID_____ Group #_____ Customer Service #_____

Claims Address (found on back of card)_____

Medicaid Number_____ Effective Date_____

In Harmony Pediatric Therapy

Family Background

Mother's Name _____ DOB _____ Occupation _____

Father's Name _____ DOB _____ Occupation _____

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

Who does child live with?_____

Does your child have siblings? ☐ Yes ☐ No Names & ages of siblings_____

_____

Languages Spoken at Home (circle primary) _____ Religious Preference _____

Is your child adopted? ☐ Yes ☐ No Adoption Background _____

What are your priorities in coming to therapy?

_____

_____

_____

Is your child currently receiving therapy services? ☐ Yes ☐ No

If "Yes", where and duration? _____

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

If "Yes", where and when? _____

Medical History

At how many weeks was your child born? _____ Birth weight? _____ Vaginal or C-section

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 or significant family history _____

Allergies

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

Current medications

Name	Dosage	Frequency	Reason for medication

Milestones

Activity	Age	Comments
Rolling		
Sitting		
Crawling		
Walking		
First words		
First Sentence		

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**

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**

_____ **If my treating therapist is out of the office, I agree to another therapist to cover.**

In Harmony Pediatric Therapy

Financial and Insurance Policy

Thank you for choosing *In Harmony Pediatric Therapy*, a collaboration of providers with Rising Stars Children's Therapy, Inc., (RSCT) 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.

Therabeat, Inc. is out of network for all providers and BCBS does not pay for music therapy. RSCT is an in-network provider for BCBS, Cigna and 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. It is also important to make us aware if your child is receiving therapy services elsewhere. All companies within *In Harmony Pediatric Therapy* accept cash, check, VISA, MASTERCARD, American Express, and Discover. There is a $50 fee for all returned checks.

If your child has Medicaid coverage, you are responsible for informing billing managers if there is a change in your child's Medicaid status. If Medicaid coverage has been terminated or is pending approval, and you continue with services, you will accept financial responsibility for the services rendered. **Therabeat, Inc. is not a Medicaid provider for music therapy services.**

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 **$35 late fee charge and an 18% annual interest fee (1.5%/month), Any lawyer and court fees will also be the responsibility of the family.**

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**

Attendance Policy

Your child's progress depends on your family's commitment to therapy. When you schedule an appointment with our clinic, you are "reserving" the therapist's time. Therefore, we must adhere to the following strict cancellation policy.
In Harmony Pediatric Therapy's policy states that we require a 24-hour notice for cancellations. For land-based services, after a one-time courtesy occurrence, a **$50 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. PLEASE ENSURE YOU INFORM THERAPISTS OF SCHEDULE CHANGES DURING HOLIDAYS, SCHOOL BREAKS AND SUMMER BREAKS.** If attendance becomes an issue and you are not able to make your appointments, understand that we will need to 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/Legal Guardian Signature_____**Date:**_____

HIPAA OMNIBUS RULE

Rising Stars Children's Therapy, Inc. and Therabeat, Inc. at In Harmony Pediatric Therapy
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT BE SENT TO OTHER THERAPIST / FACILITIES IN THE FUTURE.

_____ _____
Please *print* name of Patient Please *sign* for Patient / Guardian of Patient

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access through written or verbal communication to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Other Therapists_____

School Name: _____

Please list any other/s _____

Please indicate any custody, divorce or family matters we should be aware of_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation ☐ Any of the Above

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation ☐ Any of the Above

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent. By signing below, you acknowledge understanding and acceptance of the In Harmony Pediatric Therapy HIPAA Private Practice Notice.

Parent/Legal Guardian Signature **Date** **Printed Name**

Permission for Family to Leave Site During Treatment

_____I decline permission to leave facility

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

Consent for Audio/Visual Release

_____I decline the taking of audio/visual material

I _____ give permission for _____ to be audio or video recorded by the therapists at In Harmony Pediatric Therapy. These audio or video 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 recordings and your child's full identity will remain confidential. These recordings may be maintained in a locked facility.

Parent/Legal Guardian Signature _____**Date**_____

Consent of Photograph Release

_____I decline the taking of photographs

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). Full names and child's information will be kept confidential.

Parent/Legal Guardian Signature _____ **Date:**_____