

Patient Intake/History Form

General Information			
Patient Name:			
Sex:	M F	Date of Birth:	Mo: Day: Yr:
Primary Care Physician:			
Parent's Name:			
Address:		Phone: Home	Work:
City:		State:	Zip:
Emergency Contact:		Relationship:	Phone:
Reason for therapy referral:			
Known Allergies:			
Current Medications:			
Medical/Surgical History(Prior hospitalizations, surgeries):			
Childhood Diseases:			

Patient Intake/History Form cont.

Please specify any religious/cultural considerations:

Is there anything we need to know that is not covered on this form? If so please explain:

Patient's goals for treatment:

Patient or Parent/Guardian Signature

Date

**IN CASE OF AN EMERGENCY, PLEASE PERFORM ANY LIFE SAVING TECHNIQUE
(I.E. CPR, HEIMLICH MANUEVER) THAT YOU DEEM NECESSARY IN ORDER TO
PRESERVE THE LIFE OF MY CHILD.**

Parent/Guardian Signature

Date

How did you hear about us?

_____ Doctor referral

_____ Internet

_____ Current patient/friend

Other: _____



This Admissions Packet Includes:
Attendance Policy
Notice Regarding Insurance Changes
Patient Authorization/Consent to Treatment

Please sign and date in the appropriate boxed area at the end of each section. Please do not hesitate to ask any questions regarding the information in this packet.

ATTENDANCE POLICY

ACHIEVE Pediatric Therapy and Rehab strives to provide each patient with the highest quality of care while accommodating your schedule. We reserve time allotments for each patient; therefore, keeping your appointments on a consistent basis is a key factor in making progress with your/your child's therapy goals and care plan.

We respectfully request a **24 hour notice** of appointment cancellations. We do understand on occasions unavoidable situations which will prevent you from getting to therapy. If we do not receive advanced notice of a cancellation, it will be considered a "no show-no call" episode.

You will be charged a fee of \$50 in the event that you do not provide advance notice regarding a cancellation. It is our policy that if a patient has 2 "no show-no call" episode or 3 consecutive cancellations, that their treatment program may be terminated.

I have read and understand the above attendance policy.

Patient/Parent signature

Date

INSURANCE CHANGES

Please notify our office immediately of any insurance changes made to your policy. For example: Change to a different primary insurance due to Employer group **OR** change in your PCP or Physician group **OR** change in insurance type (such as PPO, HMO, POS, EPO). The changes are usually effective the first of each month. Failure to notify ACHIEVE of changes may result in patient financial obligation for all unpaid charges.

I have read and understand the above Insurance Changes policy.

Patient/Parent signature

Date

PATIENT AUTHORIZATION/CONSENT TO TREATMENT

Authorization to Release Information:

The patient, or his/her legal guardian, agrees to the release of general information as concerns his/her therapy treatment upon receipt of an inquiry directed to ACHIEVE. In addition, patient, or legal guardian, agrees to the release of all medical records and pertinent medical information for this outpatient admission to any insurer, governmental agency providing benefits, or to anyone liable for therapy charges.

Authorization of Assignment of Insurance Benefits:

The patient, or legal guardian, assigns to and authorizes payment directly to ACHIEVE Pediatric Therapy & Rehab all benefits payable under the terms of any insurance policy providing benefits for outpatient charges. The patient, or legal guardian, assumes responsibility for any health insurance deductions and co-payments responsibility of remaining reasonable charges. The undersigned, whether one or more, agrees to pay any charges of ACHIEVE Pediatric Therapy & Rehab in excess of benefits paid. If the patient is covered by Medicaid, he hereby assigns to the Texas State Board of Health all claims against third parties, including tortfeasors and insurance companies, who may be liable for any of the medical expense to the extent that such expenses are paid by Medicaid.

Guarantee of Account:

In consideration of the therapy services furnished and to be furnished by ACHIEVE Pediatric Therapy & Rehab, I/We hereby guarantee to you the payment of the account for services rendered or to be rendered to said patient (together with previously incurred and yet unpaid charges). I/We agree to pay these accounts when due. For the payment of such accounts I hereby waive all claims of exemption and agree to pay a reasonable attorney's fee for the collection of these accounts if placed in the hands of an attorney for collection. I/We agree to abide by all rules and regulations of ACHIEVE Pediatric Therapy & Rehab.

Consent to Treatment:

This constitutes consent to admit to outpatient therapy at ACHIEVE Pediatric Therapy & Rehab and to perform such routine treatment as ordered by your physician, physician's assistant, or nurse practitioner. It is acknowledged that the practice of medicine is not an exact science and that no guarantees have been made as to the result of treatment as an outpatient.

I have read and understand the above paragraphs about the Authorization to Release Information, Authorization of Assignment of Insurance Benefits, Guaranty of Account, and Consent to Treatment.

Patient/Parent signature

Date

Consent for the Use and Disclosure of Protected Health Information

By signing below, you consent to the use and disclosure of your protected health information by ACHIEVE PEDIATRIC THERAPY & REHAB, our staff and our business associates for treatment, payment and health care operations purposes. For a more detailed description of our uses and disclosure of protected health information, please review our Notice of Privacy Practices ("Notice"), which you acknowledge receiving on this date. You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting us at 512-260-6990 and requesting a revised Notice. You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. Finally, you have the right to revoke the consent in writing, except to the extent that we have taken action in reliance on it.

AGREED AND ACKNOWLEDGED: _____

Patient/Parent Signature

Date

My email address is: _____.

Our office may occasionally email you regarding your child's therapy and/or performance during therapy. Also, our office will email any office closures, schedule changes, account/insurance notices, and special events. I understand that email is NOT a secure form of communication.

- ☐ Information regarding my child's therapy session and/or performance can be released to the following individuals:

Name

Relationship

Name

Relationship

Name

Relationship

Patient/Parent Signature

Date



2021 Insurance Verification Agreement

At Achieve Pediatric Therapy & Rehab, we strive to provide the highest quality pediatric therapy and we believe that includes working with families and empowering them to understand their insurance benefits. In order for us to continue this quality of service, we are encouraging our Achieve families to do the following:

- Notify Achieve Front Office staff of **ANY** insurance changes **ASAP** (New Plan, Policy #, Insurance Carrier, etc.)
 - There are some insurance policies that require authorization be obtained prior to the start of therapy services or before first visit on new insurance. **Failure to notify the front office of any insurance changes, may result in the visit/s not being covered by insurance and will fall to patient responsibility.**
- **Verify/Keep Track of Your Visit Limits**
 - As a courtesy, we have a system and do our best to track visit limitations. It is also the responsibility of each guarantor/payee to know your therapy visit limitations and to keep track of them. This will help you make financial decisions and be prepared for when therapy visits run out. **Failure to know/track your therapy visit limitations could result in visits past the limit not being covered by insurance and will fall to patient responsibility.**
 - To verify your therapy coverage and visit limitations please call your insurance company's Member Services and ask about therapy benefits and ask "How many visits of OT/PT/ST does my child receive per year." Be sure to clarify if the limit is "per discipline" or "combined".

Please remember that insurance coverage/limits for therapy services is NOT a guarantee of payment. Any therapy visit that takes place at Achieve Pediatric Therapy & Rehab and is not covered by insurance will fall to patient responsibility. We appreciate your partnership in this. Please sign below acknowledging that you have received this information.

I acknowledge that I have reviewed Achieve Pediatric Therapy & Rehab's 2021 Insurance Verification Agreement.

Patient's Name

Guarantor's Signature

Date



NOTIFICATION OF PATIENT FINANCIAL RESPONSIBILITY

As a courtesy, Achieve has contacted your insurance company to obtain a quote of your benefits. Please note that we cannot guarantee the verbal quotes we receive and benefits quoted to us are NOT a guarantee of payment. Your plan may be subject to other plan limitations or exclusions.

Your insurance company requires Achieve to collect your co-payment or unmet deductible amount at the time of service or we could be in violation of our contract with your insurance company and risk not being reimbursed for your treatment process. We will collect the estimated quote that was provided to us from your insurance company. We will notify you of any changes in the payment due when we receive your claims back from insurance.

We will bill your insurance company for their portion of the bill. If for any reason insurance denies paying any claims you will be held financially responsible for full payment. Evaluations are \$200 and all treatment rates are \$112.50.

Please be sure to inform us as soon as possible of any insurance changes as this may affect the amount we collect.

We are required to collect payment prior to the start of each treatment session. It is our policy that payment is due at time of service. Our office staff can accept payment from you with check, cash or credit card. Please note that the evaluation is a one-time charge that covers information gathering, formal testing, and a formal written report of results/recommendations. Each visit after the initial session will be billed as a therapy treatment. The needs of each child are unique making it difficult to estimate how long formal testing will take with your child. If your child's evaluation testing is not completed at your initial session, it will be completed during your first treatment session. In this case, we are still required to charge the treatment rate starting at the second visit. Also, based on the individual needs of children, a re-evaluation may be necessary every 6-12 months. Re-evaluations may increase the charge for one visit.

Your insurance policy may have visit limits on the amount of therapy they cover per year. We strongly recommend that you verify your limits and keep track of your child's therapy visits.

Any visits that occur outside of your policy limit will be billed to you at our full out-of-pocket rate. Please verify that you understand your financial responsibility by signing and dating this form and let us know if we can assist you in any other way. Thank you.

Patient Name (Printed)

Date

Patient/Guardian Signature

Date

Achieve Pediatric Therapy and Rehab Insurance and Patient Billing

As a courtesy, your claims will be submitted to any in-network medical insurance plan for which you provide information and in which you are currently enrolled. To ensure accuracy with your financial responsibility, you will be billed for any balances considered to be the responsibility of the member after the insurance company has processed your claim and sent our office the remittance advice. This can take up to 4-6 weeks, but is often times less. This delay means you will most likely not receive a billing statement from until a few weeks after the date of service. It is not uncommon for claims to be processed out of order or for several dates of service to be processed all at one time, this is not something we have control over and is managed by your insurance. Please keep this in mind when planning and viewing statements from our office.

In most cases, OT/PT/ST is a reoccurring and a weekly event. For ease of payments and to avoid disruption of your child's therapy services, we offer a secure option to leave a payment card on file to charge as remittance advice is received from your insurance. You will receive a statement of what's due before your card is charged. Your card will only be charged for dates of service and amounts that your insurance has determined is your patient responsibility. While most of our patients leave a payment card on file with us, it is not required. If you do not leave a card on file, you may call to make a payment over the phone or come into our office to make a payment in person. Patients with account balances over 15 days old will need to be placed on hold until payment is made.

Here is a quick reference as to how the billing process works in our office:

Step 1: Therapy Service Received, Therapist documents charge.

Step 2: Billing office submits claim for the prior day's therapy sessions

**2-4 Weeks from Date of Service: ERA (electronic remittance advice) is received through Achieve's EHR system. Payment is posted to client account and member responsibility is invoiced to your account and sent to you in a statement. Patient balance is charged weekly.*

*2-4 weeks is an estimate and varies by insurance carrier. It is not uncommon for claims to be processed out of order or for multiple dates of service to be processed at one time.

Our customer service team at Achieve Pediatric Therapy and Rehab is available to assist you with questions you may have regarding your patient statement/billing. We offer convenient ways to contact us regarding your account. You may contact us via telephone (806-853-9740, opt 2).

**Achieve Pediatric Therapy & Rehab Credit Card Authorization Form
2021**

Achieve Pediatric Therapy & Rehab
5211 79th St
Lubbock, TX 794
806-853-9740

You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

I, _____, authorize Achieve Pediatric Therapy & Rehab to charge the credit card I have left on file for Physical/Occupational/Speech therapy services for my child. I understand that my information will be saved on file for future transactions on my account. A statement for all charges is available upon request.

Patient Name(s)

Guarantor Signature

Date

Achieve Pediatric Therapy and Rehab, P.C.

WAIVER OF LIABILITY AND HOLD HARMLESS AGREEMENT

In consideration for receiving permission to BE ON PREMISES at Achieve Pediatric Therapy and Rehab (hereinafter the "Activity or Activities"), I, on behalf of myself and any minor child/children for whom I have the capacity to contract, hereby acknowledge and agree to the following:

1. I understand the hazards of the novel coronavirus ("COVID-19") and am familiar with the Centers for Disease Control and Prevention ("CDC") guidelines regarding COVID-19. I acknowledge and understand that the circumstances regarding COVID-19 are changing from day to day and that, accordingly, the CDC guidelines are regularly modified and updated and I accept full responsibility for familiarizing myself with the most recent updates.
2. Notwithstanding the risks associated with COVID-19, which I readily acknowledge, I hereby willingly choose to participate in Activities.
3. I acknowledge and fully assume the risk of illness or death related to COVID-19 arising from my being on the premises and participating in the Activities and hereby RELEASE, WAIVE, DISCHARGE, AND COVENANT NOT TO SUE (on behalf of myself and any minor children from whom I have the capacity contract) Achieve Pediatric Therapy and Rehab, P.C., their owners, officers, directors, employees and assigns (the "RELEASEES") from any liability related to COVID-19 which might occur as a result my being on the premises and participating in the Activities.
4. I shall indemnify, defend and hold harmless the RELEASEES from and against any and all claims, demands, suits, judgments, losses or expenses of any nature whatsoever (including, without limitation, attorneys' fees, costs and disbursements, whether of in-house or outside counsel and whether or not an action is brought, on appeal or otherwise), arising from or out of, or relating to, directly or indirectly, the infection of COVID-19 or any other illness or injury.
5. It is my express intent that this Waiver and Hold Harmless Agreement shall bind any assigns and representatives, and shall be deemed as a RELEASE, WAIVER, DISCHARGE, AND COVENANT NOT TO SUE the above-named RELEASEES. This Agreement and the provisions contained herein shall be construed, interpreted and controlled according to the laws of the State of Texas. I HEREBY KNOWINGLY AND VOLUNTARILY WAIVE ANY RIGHT TO A JURY TRIAL OF ANY DISPUTE ARISING IN CONNECTION WITH THIS AGREEMENT. I ACKNOWLEDGE THAT THIS WAIVER WAS EXPRESSLY NEGOTIATED AND IS A MATERIAL INDUCEMENT THE PERMISSION GRANTED BY RELEASEES TO BE ON PREMISES AND PARTICIPATE IN THE ACTIVITIES.

IN SIGNING THIS AGREEMENT, I ACKNOWLEDGE AND REPRESENT THAT I have read the foregoing Wavier of Liability and Hold Harmless Agreement, understand it and sign it voluntarily as my own free act and deed; no oral representations, statements, or inducements, apart from the foregoing written agreement, have been made; I am at least eighteen (18) years of age and fully competent; and I execute this Agreement for full, adequate and complete consideration fully intending to be bound by same. IN WITNESS WHEREOF, I have signed this Waiver and Agreement under seal on this

_____ day of _____, 20_____.

SIGNATURE: _____

NAME: _____

NAMES OF MINOR CHILD(REN): _____

Achieve Pediatric Therapy & Rehab
Teletherapy Informed Consent Form

I _____ (parent/guardian) hereby consent to engage in teletherapy with Achieve Pediatric Therapy & Rehab. I understand that “teletherapy” includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical/mental information, both orally and visually.

I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. Unless explicitly agreed otherwise, the teletherapy exchange is confidential. Any personal information I choose to share will be held in the strictest confidence. The laws that protect the confidentiality of my medical information also apply to teletherapy. Just as with face-to-face clients, the clinician will not release your information to anyone without your prior approval, or required to do so by law. In Texas mental health providers are required to notify authorities if they become convinced a client is about to physically harm someone; or if they are abusing, or about to abuse, children, the elderly, or the disabled.
3. You understand that this teletherapy occurs in the state of Texas, (USA), and is governed by the laws of that state. In a manner of speaking, you use modality to visit the therapist in his/her Texas office.
4. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the clinician, that: the transmission of my information could be disrupted or distorted by technical failures; and/or the transmission of my information could be interrupted by unauthorized persons.
5. In addition, I understand that teletherapy based services and care may not be as complete as face- to-face services. I also understand that if the therapist believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to an in clinic visit. Finally, I understand that there are potential risks and benefits associated with any form of therapy.
6. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.
7. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session, (4) if I decide to keep copies of emails or communication on my computer, it is up to me to keep that information secure.
8. I understand that while email may be used to communicate with the clinician, confidentiality of emails cannot be guaranteed.
9. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

I have read, understand and agree to the information provided above.

Parent/Guardian Signature

Child's Name

Date



Achieve Pediatric Therapy & Rehab allows high school and undergraduate student volunteer/observation in our facility. These volunteers are interested in pursuing a career in physical, occupational or speech therapy. As a part of graduate school requirements, these students must receive several hours of observation in their field of interest to apply to graduate school. Each volunteer has been educated on confidentiality and has a signed confidentiality form on file. These students carry out a variety of tasks in our clinic and also get the opportunity to observe therapy sessions. These volunteers only come into contact with children when accompanied by the child's treating therapist and are never left unsupervised with a child. Please check the appropriate box below as it pertains to your child and student observers.

- ☐ YES, I allow student observations/volunteers during my child's therapy sessions.
- ☐ NO, I do NOT allow student observations/volunteers during my child's therapy sessions.

X

Parent Signature

X

Date