PATIENT REGISTRATION FORM

Child's Name: (Last) _____ (First) _____

Birth Date: _____ Sex: ☐ (M) ☐ (F)

Address: _____

City_____ State _____ Zip _____

Parent/Caregiver Name:	Phone Number:	Email:

Primary Care Physician: _____

Referring Doctor (if different): _____

Contact Information Policy:

When you provide your contact information, you authorize Total Pediatric Therapy ("TPT") and it's agents to use the mailing address, email address, and telephone numbers you provide, for the purpose of communicating with you regarding appointment information, account information, or other clinical or non-clinical information pertinent to services rendered by "TPT." You also agree to accept live calls, automated calls, texts, or other messages from "TPT" and it's agents as well as grant them to leave recorded messages.

Patient Consent and Release for Treatment:

I request and consent to the performance of evaluation, treatment, and procedures. I understand that I am free to withdraw my consent and that I may stop treatment or any procedure at any time.

I understand that I am financially responsible for all the charges of all services rendered of litigation, insurance reimbursement, or pending L&I claims. I understand, as the parent/legal guardian authorizing treatment for a minor, I will be responsible for the payment.

All patients under 18 years of age must have a parent/legal guardian present during all appointments. "TPT" shall have power of attorney to make any emergency medical decisions necessary or appropriate for any unaccompanied minor patient. Patient and his or heirs, parents, and guardians hereby release and forever waive any liability towards "TPT" and its agents, employees, and representatives from any action that arises under the employment of such power or any other claim related to the exercises of this provision.

Insurance Information and Financial Policy:

Primary Insurance Company _____

Policy/Member ID #_____ Group #_____

Policy Holder's Name _____ Policy Holder's DOB: _____

All professional services rendered are the ultimate responsibility of the patient. As a courtesy, we will bill the primary insurance company, if we are provided the necessary information. You are authorizing "TPT" to release any necessary information requested by your insurance carrier and authorize payment directly to "TPT" for any benefits available under your insurance plan.

Co-payments are due at the time of service. The first time a co-payment is processed in the office, the credit card will be held on file and processed for future co-payment charges. This card can also be used to process deductible amounts, co-insurances, and no-show fees. All patient balances must be paid within three (3) months of the last date of service, unless an approved payment plan has been created. For ongoing patients, all balances must be paid in full once the total invoiced amount reaches $100. It is important to communicate any financial problems as soon as possible. Please contact the business office directly to discuss a mutually agreeable payment plan so you will not jeopardize your credit. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. In the event of non-payment and/or no payment plan, formal collections procedures may become necessary and you will be responsible for an additional 35% due to collection agency costs.

Your insurance is a contract between you, your employer (if necessary), and your insurance company. We are not a party to that contract. As a courtesy, we will call to verify and obtain benefits as well as collect from your insurance company. However, primary responsibility for understanding coverage limits belongs to the parent/legal guardian. Additionally, it is the parent/legal guardian's responsibility to follow up with their insurance company on all unpaid visits.

Should your insurance deny payment or coverage for any reason, you are responsible for any and all charges billed. A statement will be emailed to you after the denial has been received from your insurance company. This notice will hold for the duration of your treatment. These denials MAY INCLUDE, but not be limited to Medical Necessity, Required Documentation Missing, Processing Dispute, Exceeds Plan Limits, Investigational Code, Preauthorization/Predetermination not obtained by patient or "TPT".

ANY CHANGES IN INSURANCE POLICIES MUST BE REPORTED TO TOTAL PEDIATRIC THERAPY WITHIN 24 HOURS. This will ensure proper continuation of coverage. It is the responsibility of the parent/legal guardian to cover the costs of any services that are not covered or are denied by your insurance.

No-Show Policy:

We require text or phone notification for all cancellations. A notice of 24 hours is preferred, but we require at least 60 minutes. If a therapy session is cancelled with less than 60 minutes notice or no showed, a fee of $40 will be assessed to the family. This charge will not be covered by insurance, but will have to be paid by you personally. If a patient is late for their appointment, effort will be made to still see the patient, but there is no guarantee. Three no-shows within a three-month period will result in removal from our schedule.

Divorce Policy:

In the case of divorce, it is our policy that any amount owed, after insurance has paid, will be the responsibility of the parent who brings the child for their first appointment and initiates care. We do not bill to anyone other than the parent who initiated care.

Illness/COVID Policy:

- We require children to be symptom and fever-free for at least 24 hours prior to returning for a session. If a child is on an antibiotic for an illness, the medication must be administered for at least 24 hours before returning to the clinic.
- The novel Coronavirus, COVID-19, has been declared as a worldwide pandemic by the World Health Organization. It is contagious and is believed to spread from person to person contact. "TPT" has put into place preventative measures to reduce the spread of COVID-19 including, but not limited to: thorough cleaning of the facilities, handwashing protocols, and optional masking procedures. However, "TPT" cannot guarantee that you and/or your child will not become infected with COVID-19. By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that my child/or I may be exposed to or infected by COVID-19 by attending "TPT" and such exposure or infection may result in personal injury, illness, disability, or death. I voluntarily agree to assume all of the forgoing risks and accept the sole responsibility for exposure to my child and/or myself that may be experienced or incurred in connection with my child's attendance at "TPT". On my behalf, and on behalf of my child, I hereby release, covenant not to sue and hold harmless "TPT", it's employees, agents and representatives from any liability, claims, actions, damages, or expenses of any kind arising out of or relating to COVID-19 exposure while at "TPT". I understand and agree that this release includes any claims based on the actions, omissions, or negligence of "TPT", it's employees, agents, and representatives, whether a COVID-19 infection occurs before, during or after participation in any service at "TPT".

HIPAA Notification Policy:

Please review our Notice of Privacy Practices carefully.

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient (parent/legal guardian), you have the following rights:

1. The right to request corrections to your information;
2. The right to request that information be restricted;
3. The right to request confidential communications;
4. The right to a report or disclosure of your information; and
5. The right to a paper copy of this notice.

We may use and disclose health information about your child for treatment, payment, and healthcare operations. We may also use and disclose your health information to the patients referring doctor and/or primary care physician.

We want to assure you that your medical/protected health information is secure with us. This notice contains information about how we will ensure your information remains private. If you have any questions about this notice, the name and phone number of our contact person(s) is listed below.

Katie Prenovost, Director of Outpatient Therapy	480.588.3656	Katie@TotalPeds.com
Coral Robinson, Clinic Manager	480.588.3656, Ext 5	Coral@TotalPeds.com

Acknowledgement of Notice of Privacy Practices: I understand that if I have questions or complaints regarding my privacy rights that I may contact the person(s) listed above. I understand that I can request a copy of this notice at any time. I further understand that the practice will offer me updates to this notice of privacy should it be amended, modified, or changed in any way.

Video and Photography Policy and Release:

Therapists and staff at "TPT" often video or photograph children who receive therapy services to help monitor and document a child's areas of concern, as well as progress. Videos and photos are used and reviewed only by "TPT" staff.

I do/do not DO NOT _____ give consent for my child to be videotaped and/or photographed as part of his/her therapy program for use by "TPT" staff only.

Therapists and staff at "TPT" frequently use video and/or photographs from a child's session for educational purposes or to share on social media for promotional purposes. These videos and/or images may be used in print publications, online publications, presentations, websites, and social media. I understand that my child's name and any identifying information will not be used in association with these videos and/or images. Additionally, I understand that no royalty fee or other compensation shall become payable to me for the use of these videos and/or photographs.

I do/do not DO NOT _____ give consent for my child to be videotaped and/or photographed for educational and public relation purposes.

Signing Below:

By signing below, you the parent/legal guardian are attesting that you have voluntarily entered into an agreement with Total Pediatric Therapy. Your signature indicates you have read and understand the following:

- Contact Information Policy
- Patient Consent and Release for Treatment
- Accurate Insurance Information has been provided
- Financial Policy
- Any changes to insurance policies will be reported within 24 hours
- No-Show Policy
- Divorce Policy
- Illness/COVID Policy
- HIPAA Notification Policy
- Video and Photography Policy and Release

I am the parent/legal guardian of the minor patient, and hereby agree to the terms above.

Child's Name _____ Parent/Legal Guardian Name _____

Parent/Legal Guardian Signature _____ Date _____