

# PATIENT REGISTRATION FORM

## PERSONAL INFORMATION

Child's Full Name :

Date Of Birth :  Gender : ☐ Male ☐ Female

Address :

Parent/Caregiver Name:	Phone Number:	Email:
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Primary Care/Referring Physician :

## INSURANCE INFORMATION

Primary Insurance Company :

Policy/Member ID # :  Group # :

Policy Holder Name :  Policy Holder DOB :

## VIDEO & PHOTOGRAPHY POLICY & RELEASE

☐ I do ☐ 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.**

☐ I do ☐ do not give consent for my child to be videotaped and/or photographed **for educational and public relation purposes** such as website, brochures, teaching and social media purposes.

## OVER THE AGE OF 18

If your child is over the age of 18, do you have guardianship letters or power of attorney allowing us to communicate directly with you regarding your child's care? ☐ Yes ☐ No

If **yes**, we require a copy of this document prior to initiating treatment. You may email it to [Info@TotalPeds.com](mailto:Info@TotalPeds.com) or bring it in on the day of your child's evaluation.

If **no**, do you as the patient, allow for us to share your medical or appointment information with anyone else? If so, list their name here:

## PATIENT CONSENT & 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. 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.

## NO SHOW/CANCELLATION POLICY

We require text or phone notification for all cancellations 24 hours in advance. **If a PT/OT/Speech session is canceled with less than 24 hours notice or no showed, a fee of \$50 will be assessed to the family. If a reading program session is canceled with less than 24 hours notice or no showed, the entire fee for services will be assessed.** This charge will not be covered by insurance but will have to be paid by you personally before the patient can receive additional treatment. If a patient is late for their appointment, effort will be made to still see the patient, but there is no guarantee. Two no-shows within a three-month period will result in removal from our schedule.

## ILLNESS 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.

"TPT" has put into place preventative measures to reduce the spread of illness. However, "TPT" cannot guarantee that you and/or your child will not become infected with illness. By signing this agreement, I acknowledge the contagious nature of illnesses, such as COVID-19. 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".

## 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:

- The right to request corrections to your information;
- The right to request that information be restricted;
- The right to request confidential communications;
- The right to a report or disclosure of your information; and
- 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    [info@TotalPeds.com](mailto:info@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.

## FINANCIAL POLICY

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.

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.

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.

Co-payments are due at the time of service and deductible and co-insurance amounts are due upon invoicing. The first time a payment is processed, the card will be securely saved on file and processed for future charges. This card can also be used to process deductible amounts, co-insurances, and no-show fees. 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. We reserve the right to stop ongoing treatment if payment from previous delivered care is not received.

\*\*\* In the case of divorce, it is our policy that any amount owed, 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.

## CONTACT INFORMATION POLICY

When you provide your contact information, you authorize Total Pediatric Therapy ("TPT") and its 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, texts, or other messages from "TPT" and its agents as well as grant them to leave recorded messages.

\*\*\* If you have a situation where someone you do not authorize may attempt to gain information from our facility, we do have the option of providing a pin number. If the caller does not provide us with this pin number, we will automatically know that they are not an approved person. If this is something you would like to initiate for your child, please check yes. ☐ YES ☐ NO If yes, list PIN# here:

## SIGNATURES

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:

- |   |                              |
|---|------------------------------|
| • Video & Photography Release               | • Illness Policy             |
| • Over the age of 18                        | • HIPAA Notification Policy  |
| • Patient Consent and Release for Treatment | • Financial Policy           |
| • No-Show Policy                            | • Contact Information Policy |

Patient/Child's Name :

Patient OR Parent/Legal Guardian Name :

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_