Physical Therapy for Kids

Sharon Skidmore, PT, DPT
www.ptforkids.com

Date:_____

Child's Legal Name: _____ Goes by:_____ Birth date:_____

Mother/Guardian:_____ Father/Guardian:_____

Address:_____ Address: _____

City, Zip: _____ City, Zip: _____

Phone:_____ Phone:_____

*Agree to voicemail ? Yes_____ No_____(initial) *Agree to voicemail ? Yes_____ No_____(initial)

*Agree to text ? Yes_____ No_____(initial) *Agree to text? Yes_____ No_____(initial)

Primary phone Yes_____ No_____ Primary phone Yes_____ No_____

Alternate Phone: _____ Alternate Phone: _____

E-mail:_____ E-mail:_____

*Agree to e-mail? Yes_____ No_____(initial) *Agree to e-mail ? Yes_____ No_____(initial)

Preferred method of contact (please number in order): Text_____ Phone/voicemail_____ E-mail_____

*Refer to Electronic Communications Policy and Consent form

Employer:_____ Employer:_____

Work Phone:_____ Work Phone:_____

Child lives with:_____

Legal Custody: Joint_____ Mother_____ Father_____ Other (please list)_____

Emergency Contact:_____Relationship:_____Phone:_____

Other people that may bring your child to therapy:_____

_____

*It is ok to share therapy related information about my child with this person/people. Yes_____ No_____(please initial)

Primary Care Doctor: _____ Clinic:_____

Other Doctors/Specialists:_____ Clinic:_____

_____ Clinic:_____

OT: _____ Clinic:_____

Speech: _____ Clinic:_____

Other: _____ Clinic:_____

Per HIPAA policy, information may be shared with other healthcare providers involved in the childs care for treatment coordination.

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Consent for Treatment / Privacy Policy

I, _____ hereby authorize physical therapy evaluation and
Name of parent or legal guardian

treatment services to be provided for _____.
Legal name of child

Evaluation and Treatment
I understand that following each evaluation, progress note, or treatment plan, Dr. Skidmore will discuss physical therapy diagnoses, prognosis, treatment options, and goals with me as the parent or legal guardian of this child. I know that it is my right to have this information explained to me so that I may have an adequate understanding. It is my responsibility to ask questions for clarification if I do not understand any part. With this information it is then my right and responsibility to make choices regarding treatment options for the best interest of my child. If at any point the treatment option that I choose does not agree with Dr. Skidmore's opinion of the best plan of care, physical therapy services with Physical Therapy for Kids, LLC (PT for Kids, LLC) may be discontinued and I may seek my treatment option with another provider. _____(*initials*)

Attendance Policy
Twenty-four hour notice of absences is requested. I understand this is not always possible but giving as much notice as possible is considerate. Appointments missed without notice of cancellation or less than 2 hours before the scheduled time may be charged a $50.00 fee. I understand that the insurance companies do not reimburse for missed appointments: this will be the sole responsibility of the parent or legal guardian. I understand that the attendance policy for Physical Therapy for Kids, LLC is discontinuation of services if three out of six scheduled sessions are missed without notice or notice less than one hour prior to the scheduled time. The child may also be discontinued from services if four or more of eight sessions are missed with or without notice of cancellation. _____(*initials*)

Photograph and Video Records
In this age of improved technology the use of photography and video is very beneficial in assessment and treatment. I agree to have my child photographed for the purpose of evaluation, assessment of progress, and documentation as related to their therapeutic goals. All pictures/video included in the privacy policy.
_____(*initials*)
I allow pictures, videos, or documents with identifying information to be e-mailed or texted on my request/approval. _____(*initials*)
I understand use of pictures or video outside the privacy policy (i.e. presentations, study groups, web site) will not be used unless specifically requested._____(*initials*)

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA):
I acknowledge that I have received and read pages 1-4 of the Notice of Privacy Policy for Physical Therapy for Kids, LLC. I understand that this allows PT for Kids, LLC to share information regarding my child with other professionals (doctors, other therapists, equipment vendors, etc.) as related to my child's care without a separate release of information. I understand that it allows for the release of records for insurance review or auditing.
_____(*initials*)

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Child's name: _____

Electronic Communication

I acknowledge that I have received, read and understand the Electronic Communications Policy and have initialed my communication choices on the intake sheet. If I have authorized email communications, I do so with the following understanding:

E-MAIL, TEXT, AND ELECTRONIC FAX TRANSMISSION CAN BE MISDIRECTED TO OR INTERCEPTED AND DISCLOSED BY UNINTENDED THIRD PARTIES AND THUS MAY NOT A CONFIDENTIAL MEDIUM OF COMMUNICATION. PATIENTS WHO HAVE CONCERNS SHOULD CONSIDER USING ANOTHER MODE OF COMMUNICATION. PATIENTS UNDERSTAND AND AGREE THAT E-MAIL TRANSMISSION IS BEING USED FOR THE CONVENIENCE OF PATIENTS AND PHYSICAL THERAPY FOR KIDS,LLC DOES NOT WARRANT THE CONFIDENTIALITY AND SECURITY OF THIS TRANSMISSION. PATIENTS, AND IN PARTICULAR THOSE PATIENTS WHO HAVE MULTI-USER E-MAIL ACCOUNTS, ARE RESPONSIBLE FOR MAINTAINING THE CONFIDENTIALITY AND SECURITY OF THEIR OWN E-MAIL ACCOUNTS.

I have been given the risks and benefits of such services and technologies, and understand the risks associated with online communications with PT for Kids, LLC. In addition, I agree to adhere to the policies set forth above, as well as any other instructions or guidelines that PT for Kids, LLC may impose for using the electronic communications._____(*initials*)

Emergency Medical Care

In the event of a medical emergency I authorize PT for Kids, LLC to activate emergency personnel if needed and share information to allow appropriate care of my child. I will be notified as soon as possible in any medical situation. I understand any cost of medical treatment or transport incurred is my responsibility.
_____(*initials)*

My signature below signifies that I have read and agree to the above policies of PT for Kids, LLC and understand my rights and responsibilities.

_____ _____
Signature of parent or legal guardian Date

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Consent for Billing/Payment

I, _____(parent/guarantor/legal guardian) have authorized physical therapy evaluation and treatment services to be provided for _____(child) and understand that it is my responsibility to pay for all services rendered by Physical Therapy for Kids, LLC.

Please initial your choice for billing.
Please read all 4 options first to determine correct option.

1. _____ I verify that my child is covered (primary or secondary) by an **Oregon State Health Plan /Medicaid (PSCS or DMAP)** and understand that PT for Kids, LLC will bill the insurance directly as required and I authorize payment directly to PT for Kids, LLC. If for some reason my child is not eligible on the date services are provided, I understand that I will be responsible for all costs incurred. This must be selected if the child is covered by one of these plans.

2. _____ My child is covered by an **in-network** plan by First Choice Healthcare, Regence Blue Cross Blue Shield, or Pacific Source Commercial Plan where PT for Kids, LLC is a preferred provider. I request PT for Kids, LLC to **bill my insurance** and authorize payment directly to PT for Kids, LLC. I recognize that I am fully responsible for all charges, in full (to allowed insurance amount), whether or not insurance pays. Payment of any co-pays, deductibles, and balance due will be paid within 30 days of the date of the invoice. I understand that cash pay discounts do not apply this plan.

3. _____ My child is covered by an **out-of-network** plan and I elect to pay PT for Kids, LLC directly and **bill the insurance company myself**. I understand that PT for Kids, LLC will provide the appropriate documentation but is in no way responsible if my insurance does not pay or pay in full. In choosing this plan I recognize that I am fully responsible for all charges and payment of balance due will be paid within 30 days of the date of the invoice. Discounts for timely payment are available.

4. _____I elect to pay PT for Kids, LLD directly, **Cash-Pay**, and **will <u>not</u> submit billing** to my insurance company if I have one. In choosing this plan I recognize that I am fully responsible for all charges. Payment of balance due must be paid within 30 days of the date of the invoice or my account may incur service charges. Discounts for timely payment are available.
I may choose this plan if I am covered by insurance including Pacific Source Commercial Plan, First Healthcare Network Plan, or Regence Blue Cross Blue Shield but understand and agree that **it cannot be applied toward deductible or reimbursement.**

I, _____(print name), guarantee timely payment on this account including in the event that a third party payer (insurance) fails, for any reason, to pay for services. Payment in full is due within 90 days of notice regardless of insurance coverage. If I am not able to make payment, it is my responsibility to contact and meet with Dr. Skidmore or her billing service to determine a plan with reduced rates for financial hardship or extended payment plan.

I can change my option at any time, in writing, which will apply to any dates of service after the new consent is signed and received. I am responsible to notify PT for Kids if there are any changes to my child's insurance coverage or my choice for payment.

_____ _____
signature parent/guarantor/legal guardian date

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Billing/Payment Information

Child's name: _____

Complete if selected option 1 or 2 above.

*Primary Medical Insurance: _____

Policy #: _____ Group #: _____

Subscribers name: _____ Birth date: _____

SSN: _____ Employer: _____

It is the responsibility of the parent/guardian to notify PT for Kids, LLC immediately of any changes to Insurance.

*Secondary Medical Insurance: _____

Policy #: _____ Group #: _____

Subscribers name: _____ Birth date: _____

Any balance due (co-pay/ deductible/ etc.) will be invoiced monthly and sent to your email on file. You may pay on-line with credit/debit card, HSA, or bank transfer. After payment you will be able to print your receipt. If you prefer check or cash, it can be given directly to provider or mailed to PO Box 1475 Sisters, OR 97759. Receipts available on request.

Information for options 3 and 4.
Invoices are sent monthly to your email. Email for billing _____
You may pay on-line with credit/debit card, HSA, or bank transfer. After payment you will be able to print your receipt. If you prefer check or cash, it can be given directly to provider or mailed to PO Box 1475 Sisters, OR 97759 and receipts are available on request. If you selected option 3, a superbill will be generated for you to submit to your insurance along with your payment receipt.

Please note my rates are at or below the average for physical therapy in the Central Oregon area.

Cash Pay Discounts for options 3 and 4 because I do not need to submit to insurance.
Paid in full within 7 days of invoice date or if have card on file:
32% discount (estimate: 55 minute treatment= ~$150/ Evaluation = $170)
Paid in full 7-14 days of invoice date:
20% discount (estimate: 55 minute treatment =~$176/ Evaluation =$200)
Paid in full 14-30 days of invoice date:
15% discount (estimate: 55 minute treatment = ~$187 /Evaluation =$212.50)
Paid after 31 days of invoice date:
0% discount (estimate: 55 minute treatment = ~$220 /Evaluation =$250)

(Leave blank)
Reviewed Billing and Payment options with parent/guardian on _____ (date). They state understanding and agreement with their chosen option.

_____ Sharon Skidmore, PT, DPT

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Medical Information and History

Today's date:_____

Child's Name: _____ Birth date:_____

1. Does your child have a diagnosis from the doctor? _____yes _____no

   Please list with date diagnosed?_____

   _____

   _____

   Do you understand the diagnosis?_____

2. Is your child generally healthy? _____yes _____no

   If not, what kind of sicknesses do they often get?_____

   _____

3. What medications, over the counter drugs, and vitamins/supplements does your child take?

Medication / Supplement	How much/often	For what?

4. Does your child have any allergies or reactions? _____yes _____no

   To what?_____

5. Are there any movements or positions that should be avoided? _____yes _____no

   Why?_____

   _____

6. Was your child born on time or early? _____on time _____early ⇒ # weeks gestation_____

   Were there any complications? _____

   _____

7. When did you first notice they were having difficulty with their movement?_____

   What did you see? _____

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8. Has your child had any surgeries or major procedures? _____yes _____no
   Please list with month/year?_____

   _____

9. **For children under 4 years old,** approximately what age did your child:
   Roll over:_____

   Sit by themselves_____

   Stand with support_____

   Walk_____

10. What do you want your child to be able to do with the help of physical therapy?
    What are your concerns or goals?

    _____

    _____

    _____

    _____

11. What are your biggest concerns about your child's development as a whole? (i.e. feeding/eating, weight gain or loss, behavior, fine motor control, sleeping, general health, playing, fitting in with other kids, participating in the family, transporting in the car, movement, falling, safety)

    _____

    _____

    _____

    _____

    _____

12. Is there anything that I haven't asked that you would like me to know about your child or your family?

    _____

    _____

    _____

_____ _____
Name of person completing form Relationship to child

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