Welcome to Theracare Pediatrics Services

Please fill out all of the enclosed forms. We ask that you fill them out completely and sign and date where appropriate. If the forms are not filled out completely, this may result in termination of services and you will be responsible for payment of services rendered. ***Please note that we need the current insurance/doctor information, and we also need you to sign and date the form.***

Please include all private insurance. If you do not have private insurance, please provide your AHCCCS information. The Division of Developmental Disabilities (DDD) requires us to bill all private insurance before we can bill DDD/AHCCCS for services rendered.

We need to have all of these forms completed and given to your therapist no later than seven days from the initial visit.

Our therapists try to stay on schedule, but sometimes there are traffic delays, etc., so please be patient. All times are approximations and if our therapist is running 15 or more minutes late, they will contact you.

If you need to reschedule or cancel an appointment, please attempt to give a 24 hour notice and contact your therapist directly. If you call our office to cancel an appointment, we cannot guarantee that your therapist will get this message in a timely fashion.

*If you have private insurance, ***PLEASE*** keep the Explanation of Benefits (EOB's) when you receive these in the mail as these documents will assist us in billing. Please note that on occasion, the insurance company may send a check to payable to you for services rendered. We ask that you sign the check and then write "Pay to the order of Theracare PLLC. This will ensure that you are not billed for the services provided. ******If you receive a payment from your insurance company, you have 5 days to submit this payment and EOB to Theracare PLLC. If payment and EOB is not received within this timeframe, you will be billed the full amount for therapy services.*****

You may give Theracare Pediatrics and your therapist FEEDBACK by calling us at 623-547-6715 faxing us at 602-926-8617 or mailing us at: 9385 W Donald Drive, Peoria, AZ 85383. You may also give us FEEDBACK by visiting us on our website at www.theracareaz.com and clicking on the FEEDBACK link in the upper right hand corner.

Theracare Pediatrics is required to verify your insurance from time to time. This will always be done in January of every year and possibly throughout the year. **IF your insurance changes at any time, it is your responsibility to contact Theracare Pediatrics and/or your therapist and fill out a new insurance information form.**

CLIENT INFORMATION

*Client Name*_____ *ASSIST #* _____
(Therapist will have Assist #)

Client Address _____

*City*_____ *State*_____ *Zip*_____

*Phone*_____ *Sex*_____ *DOB* _____

*Parent(s)/Guardian(s)*_____

*Client Primary Doctor (Full Name)*_____

Client Doctor Address _____

*City*_____ *State*_____ *Zip*_____

*Dr. Phone #*_____ *Dr. Fax #*_____

Diagnosis _____

*DDD Support Coordinator Name*_____ *Phone* _____

INSURANCE

Insured Information *(parent/caregiver info if client is listed under insurance)*

Insured Name _____

Address _____

*City*_____ *State*_____ *Zip*_____

*Phone*_____ *Sex*_____ *DOB* _____

*Employer*_____

INSURANCE CO. INFORMATION: *Name:* _____

*Insurance Effective Date*_____ *Plan: HMO PPO Other:* _____

Billing Address _____

*City*_____ *State*_____ *Zip*_____ *Phone* _____

ID #_____ ***Group #*** _____

AUTHORIZED SIGNATURE: I hereby authorize the release of any medical or other information necessary to file a claim with my insurance company. I also request payment of government and/or insurance benefits to Theracare Pediatrics Services. I understand that I am responsible for any and all bills incurred and that any third party coverage or insurance is for the purpose of assisting me with my responsibility. If I receive a payment from the insurance company I understand that this payment along with the Explanation of Benefits needs to be submitted to Theracare Pediatrics Services. within 5 business days of receipt of this information or I will be billed directly for all services. I also have received the WELCOME TO THERACARE PEDIATRICS, form and understand that I am responsible for notifying Theracare Pediatrics and/or the therapist and that I need to fill out a new INSURANCE INFORMATION FORM within 10 days of my insurance changing. I will be responsible for all services rendered if I do not submit updated insurance information within 10 days of such change.

Signature_____ ***Date***_____

MEDICAL RELEASE

I,_____, hereby certify that I am a parent or legal guardian of
(Name of Parent/Guardian)

_____, and give Theracare Pediatrics, Inc. permission
to provide (Name of Client)

services to_____. I authorize Theracare Pediatrics, Inc. to request,
(Name of Client)

obtain, and provide medical information to and from the appropriate doctors, medical facilities, insurance companies and/or payment sources. I also authorize Theracare Pediatrics to bill my insurance company and/or other payment sources and authorize payment of benefits to Theracare Pediatrics for services provided.

CANCELLATION POLICY

If I need to cancel an appointment, I understand that I will cancel/reschedule an appointment by giving a 24-hour notice when possible. Theracare Pediatrics reserves the right to discontinue services at any time.

I also understand that the therapist will call if they are going to be more than 15 minutes late for a scheduled appointment. It is my responsibility to ensure that Theracare Pediatrics, Inc. and the therapist have my most up-to-date information to include telephone number and address. I also understand that the therapist will keep all appointments and from time to time may need to cancel/reschedule an appointment within less than 24 hours due to illness/emergency. If I feel that the therapist cancels frequently or is not providing quality services, I will contact Theracare Pediatrics immediately to resolve these issues.

_____ _____

Signature of Parent/Legal Guardian Date

Pre-Service Provider Orientation

INSTRUCTIONS: *This form is to be completed by the provider and the individual and/or responsible party receiving services prior to the initiation of services. A copy MUST be retained by the provider. The provider must also ensure that the Medical Release Form, the Insurance Intake Form, and the HIPAA Form are completed and retained by the provider.*

Provider Name: Theracare Pediatric Services.

All Speech Therapists are State Licensed and at a minimum have their Masters
All Occupational Therapists are State Licensed and at a minimum have their
Bachelor's if they graduated before 2007 or their masters After 2007
All Occupational Therapy Assistants have an Associates Degree and are supervised by An Occupational Therapist
All Physical Therapists are State Licensed .

Med Training: All Physical Therapy Assistants have an Associates Degree and are supervised by a Physical Therapist. *Under NO*

Transportation: *circumstances will our therapists give medications to clients*
Under NO circumstances will our therapists transport a client and/or their

Treatment: *family There MUST be an adult or legal guardian (over the age of 18)*
present during treatment sessions.

Client Name _____ ***Date of Birth*** _____

Address _____ ***Phone*** _____

Guardian/Responsible Party _____ ***Relationship*** _____

Emergency Contact Name _____ ***Relationship*** _____

Emergency Contact Phone _____

Support Coordinator Name _____ ***Phone*** _____

Primary Care Physician Name _____ ***Phone*** _____

Health & Medical Information

*Theracare Pediatrics, Inc. ***and its contracted therapists do not administer medications. If there is a medication log for the client, you may inform our therapist of such a log for informational purposes only.***

Current Medications _____ ***Frequency of Medications*** _____

Known Effects of Medications _____

Known Allergies (Food, bee stings, etc.) _____

Recommended responses to allergic reactions _____

Seizure Activity: Yes No If Yes, what is the frequency _____ ***Duration*** _____

Assistive/Protective Devices /Special Instructions _____

****Parent Signature*** _____ ***Date*** _____

**** SIGNATURE IS REQUIRED***

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1 Conduct, plan and direct my treatment and follow-up among the multiple healthcare and providers, school officials, and representatives for the Division of Developmental Disabilities who may be involved in that treatment directly and indirectly.
2 Obtain payment from a third party payer.
3 Conduct normal healthcare operations such as quality assessments.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of the patient's healthcare information. I understand that this organization has the right to change its Notice of Privacy Practices f~m time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.3

~I understand that I may request in writing that you restrict how the patient's private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree in writing, then you are bound to abide by such restrictions.

In an effort to reduce Theracare Pediatrics's carbon footprint, I give permission for Theracare Pediatrics and its therapist's to email me all therapy reports to include evaluations and ongoing reports. I understand that although all email services encrypt data that is sent via email, Theracare Pediatrics does not make any warrantee or guarantee the security of the data and cannot be held responsible for any breach of security. The email address I wish to have all reports sent to is:

EMAIL ADDRESS: _____

Patient/Client Name: _____

Patient/Client
Legal Caregiver Name: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the Client signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:_____Initials: _____
Reason: _____

Notice of Medical Privacy Practices

This notice describes how medical information may be used and disclosed and how you can get access to this information. Please review carefully.

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical information used or disclosed by us in any form, whether electronically or on paper, or orally, are kept properly confidential. This act gives you, the patient or patient representative, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

1 *Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers.

2 *Payment* means such activities such as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.

3 *Health care operations* includes the business aspect of running our practice, such as quality assessment and improvement activities, auditing, cost management analysis, and customer service.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you to provide appointment reminders of information about treatment alternatives or other health related benefits and services that may interest you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the provider:

1 The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a written requested restriction. If we agree to a restriction, we must abide by it unless you agree in writing to remove it.

2 The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.

3 The right to inspect and copy your health information.

4 The right to amend your protected health information.

5 The right to receive an accounting of disclosures of protected health information.

6 The right to obtain a paper copy of this notice from us upon request.

PLEASE RETAIN THIS FORM FOR YOUR RECORDS