KICK START PEDIATRIC THERAPY NETWORK
1845 Oak St. Suite 15 Northfield, Il. 60093 (847)386-6560 Fax: (847)423-6701
Email: info@kickstartptn.com www.kickstartptn.com

Reminders for your first visit!

If you have not submitted the following before your first visit plan to arrive 15 minutes early to complete the new client process. Please submit the following when you check in at the clinic (or hand them to your therapist if your child is being seen at home):

☐ The following **forms <u>complete</u>**
- ☐ Acknowledgement of Notice of Privacy Practices
- ☐ Registration Form
- ☐ Waiver and Release of Liability
- ☐ Video/Photo Consent

- ☐ Medical History
- ☐ Emergency Contact and Medical Information
- ☐ Service Agreement

☐ ***Your child's therapy prescription**: Illinois regulations require a valid prescription from your doctor for occupational therapy services. If you have asked your doctor to fax the prescription, please call our front desk to verify that it has been received.

☐ ***Your insurance card**. A copy will be made by our front office staff. If you would like to mail or fax a copy of your card ahead of time, we need both the front and back of the card.

*Early Intervention clients-these have already been provided by your service coordinator.

Please take your time and review all of the documents and information in the package. If you have any questions, please feel free to call your therapist.

Thank you and we look forward to a successful partnership with your family!

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REGISTRATION FORM

(Please Print Clearly)

Section I: **Child's Information** **Date_____**

Name: _____ I prefer to be called: _____

Address: _____City:_____State:_____Zip_____

Date of Birth: _____ Age: _____ Male: _____ Female: _____

Section II. **Parent/Guardian #1 Information**

Name: _____ Relationship to Patient: _____

Address: _____City:_____ State:_____ Zip:_____

Phone: (____)_____ Work Phone (____)_____ Cell Phone (____)_____

Employer_____ Occupation: _____

Email Address_____

My preferred contact number is: ☐ Home phone ☐ Work phone ☐ Cell phone
Messages can be left: ☐ Voicemail ☐ with family members ☐ only through direct communication with parents
☐ Electronic Communication (including email and text messages)

Check Appropriate Box: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Parent/Guardian #2 Information

Name:_____ Relationship to Patient: _____

Address:_____City:_____ State:_____ Zip:_____

Phone: (____)_____ Work Phone (____)_____ Cell Phone (____)_____

Employer: _____ Occupation: _____

Email Address: _____

The best time to contact me is: _____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone

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REGISTRATION FORM

Section III: Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____

Name of Employer: _____ _____Work Phone: (____)_____

Address of Employer:_____City_____State:_____Zip _____

Insurance Company_____ Group #_____ID#_____

Ins Co Address: _____ Ins Co. Phone:_____

---------- DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____

Name of Employer:_____ Work Phone: (____)_____

Address of Employer:_____City_____State:_____Zip _____

Insurance Company_____ Group #_____ ID#_____

Ins Co Address:_____ Ins Co. Phone:_____

Section IV: General Information

Pediatrician Name: _____ Office Phone: _____

Diagnosis: _____ Fax: _____

Whom may we thank for referring you? _____

Reason for referral: _____

Section V: Billing

We will be sending your monthly statements via email. Please indicate below which email address you would like us to use.

Email: _____

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SERVICE AGREEMENT (updated 1/1/2017)

Thank you for selecting Kick Start Pediatric Therapy Network, P.C. to work with your child. We believe close and thorough communication between Kick Start Pediatric Therapy Network, P.C. (herein referred to as Kick Start PTN) and our Clients is an essential element of good work and, to that end, take this opportunity to set forth the terms upon which Kick Start PTN will be providing therapeutic services to your Child. We will strive to keep you informed as to the progress of your Child, and will seek your input as to developing the therapeutic plan. Open communication is important and questions about all aspects of our work, including billing items are welcomed and will be quickly answered. We, therefore, respectfully request that you review this document carefully, and advise us if you have any comments or questions.

Kick Start PTN will be providing a variety of therapeutic services to your Child and will take all steps appropriate to meet your Child's unique needs. Notwithstanding the foregoing, any expressions on our part concerning the outcome of your Child's progress are based on our best professional judgment but are not guarantees as to the final outcome.

General Policies:

- For all home-based therapies, a parent or caregiver must be home and available for assistance (if necessary) when all services are being provided.
- Please do not have a therapist come into your home or bring your Child to the clinic if he/she shows any signs of fever, diarrhea, vomiting, lice, conjunctivitis, and/or undiagnosed rashes. Your Child must be fever-free for twenty four hours (without the aid of fever reducers) before treatment can occur. If your Child was unable to attend school earlier in the day, but then feels better, please cancel your session and allow your Child time to recover.
- To help reduce the spreading of germs we ask that you wash your child's hands upon arriving in the waiting room. Soap and water, disinfectant gel, and disinfectant wipes will be available.
- For all clinic visits your child must be supervised in the waiting room at all times by a parent or guardian. It is essential that your child be picked up from their treatment sessions on time. Late pick-up from your Child's session will accrue an additional fee based on a pro-rated treatment rate. Payment of the fee is due before your child's next treatment session.
- Kick Start PTN understands that cancellations of services are inevitable. Cancellations must be made at least twenty-four hours prior to the start of the session. If adequate notice is not received you will be assessed a $50 late cancellation fee, except in emergency situations or in cases of unexpected illness. Payment of the $50 fee is due before your child's next treatment session.
- Chronic cancellations may cause you to lose your designated treatment time or lead to termination of services.
- We are mandated by Illinois State Law to have a current prescription for occupational therapy on file.

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SERVICE AGREEMENT (1/1/2017)

Emergency Contact/Contact Information/Communication:

- For all clinic visits any changes in emergency contact information should be clearly communicated with Kick Start PTN.
- In the event of an emergency, or if your child becomes ill during treatment, the clinic will seek to contact you based on the most recent contact information in our files.
- Appointment reminders/cancellations will be communicated via contact information provided. If indicated on receipt of privacy notice messages will be left if direct contact is not possible. Please check for messages before arriving for your scheduled appointment.

Insurance:

- We are in network providers for Blue Cross Blue Shield PPO, Blue Choice, and Humana PPO and will submit insurance claims for you, per our contracts.
- If you have a different insurance company we are considered out of network. We will submit to your insurance company as a courtesy.
- If payment is not received from your insurance company within 30 business days it is your responsibility to pay the outstanding balance upon receipt of your monthly statement. When reimbursement is received for any previously paid visit, the monies will be applied to any outstanding balances over 30 days. Credit balances will be refunded within 5 business days.
- Necessary follow up with your insurance company regarding re-imbursement delays or issues is the family's responsibility. At times, as a courtesy, we may be able to speak directly with your insurance company regarding claims submitted however; it is your responsibility to follow up in regards to denied or delayed payments or claims. Any needed documentation will be provided by Kick Start PTN upon request.
- It is your responsibility to notify our office of any changes in your insurance and address.
- It is your responsibility to know your benefits and track the number of sessions. We will provide your insurance company with requested paperwork to process claims.
- You are responsible for payment of services received even if your insurance company denies coverage for any reason. Insurance companies can deny payment even after they have authorized visits if they determine services are not medically necessary.
- The decision to pay for services is made by the insurance company when the claim is received, and is based upon the insured persons' eligibility on the date of the services.

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SERVICE AGREEMENT (updated 1/1/2017)

Payment:

- Co-Payments are due at the time of service.
- Co-insurance payments are due at the end of the session or prior to the next session (payment amount will be determined based on your plans co-insurance percent of the billed treatment rate. Adjustments to under or over payment will be made upon receipt of actual insurance reimbursement and will be reflected in your account balance.
- Payments for Self-Pay clients are due at the time of service.
- Any outstanding balance is due upon receipt of the monthly invoice (the invoice will be sent via email, if you do not have access to email you may request a mailed copy).
- **Payment is due upon receive of Statement. Statements are sent bi-monthly via email.**
- Unpaid Balances passed 45 days may result in suspension or termination of services.

Additional Fees:

- **Late Cancellation** and **Late Pick Up fees** are not covered by your insurance company and must be paid prior to the beginning of the following therapy session.
- At times, we offer services and programs that are not covered by insurance policies, including but not limited to educational groups, classes, phone consultations, meetings, lectures, open gym, and parent groups. It is your responsibility to clarify if services/programs are typically covered under your insurance policy before registering.
- You will be responsible for the fees even if your insurance company refuses to pay.

Allergies/Asthma:

- If your child has been diagnosed with a severe allergy and requires assistance with an Epi-pen injection parent/guardian/caretaker should remain on the premises at all time. Epi-pen should be stored and carried with parent/guardian/caretaker.
- If your child has been diagnosed with severe asthma and requires assistance with using an inhaler, parent/guardian/caretaker should remain on the premises always. Inhaler should be stored and carried with parent/guardian/caretaker.
- If your child has been diagnosed with a severe allergy and/or asthma you need to fill out the Medication Authorization Form and have your doctor sign it and return it to your therapist.
- If your child will be self-administering an Epi-pen and or inhaler you are responsible for providing your child with a means of safely storing/carrying his/her medications.

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SERVICE AGREEMENT (1/1/2017)

No show and same day cancellation appointments: A charge of $50.00 will be assessed to your account.

Consent for treatment. I hereby consent to the treatment provided by Kick Start Pediatric Therapy Network PC and its employees or designees.

Authorization for release of personal health information. I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to my child, obtaining for my child's care, obtaining Dr.'s prescriptions for treatment, sending progress notes to referring Dr., or for the purposes of conducting the healthcare operations of Kick Start Pediatric Therapy Network PC. I authorize Kick Start PTN PC to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Kick Start PTN PC may release objective clinical information related to my diagnosis and treatment, which may be requested by my insurance or its designated agent.

Assignment of insurance benefits/Payment guarantee/Collection fees: I authorize payment to be made directly to Kick Start Pediatric Therapy Network PC, for insurance benefits payable to me. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney's fees.

Child's Name: _____

Acknowledgement: I hereby acknowledge receipt of the Kick Start Pediatric Therapy Network, P.C.'s *Service Agreement. I have read, understood and agree to the terms and conditions of this agreement.*

_____ _____ _____
Parent/Guardian Print Name Parent/Guardian Signature Date

_____ _____ _____
Guarantor (Insurance Holder) Print Name Guarantor Signature Date

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WAIVER AND RELEASE OF LIABILITY

Kick Start Pediatric Therapy Network, P.C. provides a variety of therapeutic services, programs and interventions. Some of these services may include physical activity and interaction among children as well as therapists. Such activities invariably present a degree of risk of injury. While Kick Start Pediatric Therapy Network, P.C. takes steps to reduce the risk to our clients, it is impossible to eliminate all risk. The undersigned (individually referred to herein as "I") acknowledges warrants and agrees as follows:

1. ***Assumption of risk.*** I understand that the clinical services my child receives from Kick Start Pediatric Therapy Network, P.C. include activities which may present some degree of risk. I voluntarily elect on behalf of my child (or ward) to participate in these activities with knowledge of the risk involved and hereby agree to accept and assume any and all risks of illness, injury or death.
2. ***Disclosure.*** I have disclosed all medical allergies, conditions and/or ailments which may create a greater degree of risk associated with my child's participation in these activities and/or any treatment necessary, should an incident occur that requires medical treatment.
3. ***Waiver and Release.*** By signing below, I, on behalf of myself, my heirs, agents and/or representatives, hereby waive, release and forever discharge Kick Start Pediatric Therapy Network, P.C. including without limitation its managers, members, employees, contractors, volunteers, agents and representatives, known or unknown, whether now existing or in the future, for any and all claims for physical injury or disease, including without limitation, death, which may arise out of or be considered in relation to the services provided by Kick Start Pediatric Therapy Network, P.C. The foregoing shall exclude any grossly negligent or willful or wanton acts or omissions by Kick Start Pediatric Therapy Network, P.C. This release shall be binding upon and shall inure to the benefit of the parties and their respective heirs, executors, legal representatives and successors.
4. ***Interpretation and Jurisdiction.*** I expressly agree that this Waiver and Release is intended to be as broad and inclusive as permitted by the laws of the State of Illinois, and that this Waiver and Release shall by governed by and interpreted in accordance with the laws of the State of Illinois.

Child's Name: _____

Acknowledgement:

I hereby freely and voluntarily execute this Waiver and Release of Liability.

_____ _____ _____

Parent/Guardian Print Name Parent/Guardian Signature Date

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Emergency Contact and Medical Information for a Child

Child's Name _____ Date of Birth _____ M F Sex

Parent's/Guardian's Name _____ Parent's/Guardian's Name _____

( ) _____ Home Phone ( ) _____ Work/Cell Phone (please circle)

( ) _____ Home Phone ( ) _____ Work/Cell Phone (please circle)

Address _____ Address _____

City, St. ZIP Code _____ City, St. ZIP Code _____

Alternative Emergency Contacts

Primary Emergency Contact/Relationship to Client _____ Secondary Emergency Contact/Relationship to Client _____

( ) _____ Home Phone ( ) _____ Work Phone

( ) _____ Home Phone ( ) _____ Work Phone

Address _____ Address _____

City, St. Zip Code _____ City, St Zip Code _____

Medical Information

Hospital/Clinic Preference _____

Physician's Name _____ Phone Number _____

Insurance Company _____ Policy Number _____

Allergies/Special Health Considerations _____

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

Parent's/Guardian's Signature _____ Date _____

Witness Signature _____ Date _____

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VIDEO/PHOTO CONSENT

Child's Name: _____ Date of Birth: _____
(Please print)

I give my permission for my child's photo/video to be used by Kick Start Pediatric Therapy Network for:		
evaluating and updating treatment plans	Yes	No
training his/her individual clinical team	Yes	No
research and/or professional training	Yes	No
developing customized therapy materials (e.g. communication aids; schedules; sequencing charts)	Yes	No
class/group materials and/or activities	Yes	No
marketing	Yes	No

Acknowledgement:
By signing below, I authorize Kick Start Pediatric Therapy Network to electronically and/or digitally record my child's individual therapy session and/or participation in group programs according to what is indicated above. I understand that if my child is in a group setting where pictures/videos are being taken, and used for activities specific to that group, he/she may not be able to fully participate if lacking authorization for videotaping/photographing.

_____ _____ _____
Parent/Guardian Name Parent/Guardian Signature Date

I do not authorize any form of electronic or digital recording of my child. I understand that if my child is in a group setting where pictures/videos are being taken, and/or used for activities specific to that group, he/she may not be able to fully participate in said activities if lacking written authorization for videotaping/photographing.

_____ _____ _____
Parent/Guardian Name Parent/Guardian Signature Date

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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge receipt of this office's Notice of Privacy Practices and have read, understand and agree to the terms and conditions of this Notice.

_____ _____
Parent/Guardian Print Name Date

_____
Parent/Guardian Signature

Child's Name: _____
(Please print)

Kick Start Pediatric Therapy Network, P.C. can leave messages regarding appointments:
___On answering machine/voicemail
___With family members
___At work
___Only through direct communication with parents
___ Electronic Communication including email and text messages

_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
___Individual refused to sign
___Communication barriers prohibited obtaining the acknowledgement
___Other (please specify):

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Fee Schedule as of January 1st, 2017

Treatment

*Individual OT sessions…… $160
*Individual ST (Speech & Language…… $130
*Offsite individual treatment sessions (60 minutes)…… $160

Assessments

Occupational Therapy Evaluation:

*Developmental instruments covering multiple functional areas. Includes interpretation, testing, written report, and follow up meeting with parents/guardians…….. $600

Speech/Language Therapy Evaluation:

* Includes interpretation, testing, written report, and follow up meeting with parents/guardians……. $500

*Feeding, eating consultation with written recommendations…… $225

Meetings/Consultations

*Offsite meetings, school consultations, school observations…… $160
(For first 60 minutes, $50 per additional 15 min. unit)
*Onsite meetings (team meetings/parent consultation) Day: Treatment rate
Evening: Offsite meeting rate

*Phone consultation (over 15 minutes) with parents/team members…….. Pro-rated treatment rate

Documentation (as needed)

*Written report with formal evaluation……Included in assessment fee
*Initial letter of medical necessity…… N/C
*Quarterly progress notes (reflecting on progress towards goals)…… N/C
*Additional documentation for school, legal, or insurance purposes…… Pro-rated treatment rate

Travel Fee

*Per 30 minutes of travel …….. $50

No Show/Late Cancellation (Refer to service agreement) for details…… $50