# PATIENT INTAKE FORM

## CHILD'S INFORMATION

| Last Name | First Name | Date of Birth | Sex | Social Security # |
|---|---|---|---|---|
| | | | | |

## PARENT'S INFORMATION

| Last Name | First Name | Date of Birth | Sex | Social Security # |
|---|---|---|---|---|
| Home Phone | Cell Phone | Email | | |
| Street Number | City | State | Zip Code | |
| Employer | | Employer Address | | |
| Occupation | | Work Phone | | |

## OTHER PARENT'S INFORMATION

| Last Name | First Name | Date of Birth | Sex | Social Security # |
|---|---|---|---|---|
| Home Phone | Cell Phone | Email | | |
| Street Number | City | State | Zip Code | |
| Employer | | Employer Address | | |
| Occupation | | Work Phone | | |

## INSURANCE

| Primary Insurance | Name of Insured Parent |
|---|---|
| Secondary Insurance | Name of Insured Parent |

## OFFICE USE ONLY

| Referred By | Primary Concern | |
|---|---|---|
| Diagnosis Code | Date of Evaluation | Therapist |
| CPT Codes | | |

# CHILDREN IN MOTION THERAPY SERVICES
# POLICIES

_____ **Payment Policy**

1. Co-payments are due at the time of service.
2. Private pay clients must come to their appointment prepared to pay for their visits or their appointments will be rescheduled.
3. If there is a balance due on your account and consistent monthly payments are not being made, we will be asking you to make a payment. Please come to your visit prepared to pay your balance (or make a payment) or your appointment will be rescheduled.
4. Should there be open issues with your insurance company greater than 45 days, we ask that payment be made until such issues are resolved. If resolved in your favor, a settlement will be made.
5. Many of our therapists can accept debit/credit card payments through PayPal. You do not need a PayPal account and there is no cost to you. Please contact your therapist directly if this payment is of interest to you.
6. If Medicaid denies authorization, you are responsible for charges.

_____ **Cancellation Policy**

1. We require 24-hour notice for cancellation except in the case of sudden illness.
2. If less than 24-hour notice is not given or if you do not call and do not show for your appointment, there is a $50 fee that must be paid before your next scheduled appointment. This fee must be paid by you, the parent/guardian, not the insurance company.
3. You cannot **average** more than six cancellations over a 6-month period for any reason (illness, vacation, school/family activities) or you will be asked to take a break from therapy until you are able to make a solid commitment.

_____ **Illness Policy**

1. Please do not bring your child if they are ill.
2. Please do not bring your child until they have been fever-free for 24 hours without the use of medication.
3. Please do not bring your child until they are free from vomiting or diarrhea for 24 hours.
4. Please do not bring your child if you think he/she is contagious for any type of sickness, i.e., cold, pink eye, etc.

_____ **Rates**

Therapy Sessions: $128

1. If you pay privately (we do not bill your insurance) the rate is $102 per 60-minute treatment session and $75 per 45-minute session. **This amount applies even if your insurance company previously reimbursed at a different rate.**
2. If we bill your insurance and they determine that they will not pay for services, the rate is $128 per 60-minute treatment session and $75 per 45-minute treatment session.

**Evaluation (Insurance): $175** **Evaluation (Private Pay): $148**

Signature: _______________________________________________ Date: ____________________

10587 Double R Blvd., #101
Reno, NV 89521

# NOTICE OF PRIVACY PRACTICES HIPAA COMPLIANCE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records or other health information be kept confidential. Personal information regarding your child may only be used for public health purposes, treatment, payment, and health operations, including equipment vendors.

**TREATMENT:** Providing, managing healthcare with other health providers.

**PAYMENT:** Confirming coverage, reimbursement for services, billing, and collection.

**HEALTH CARE OPERATIONS:** Business aspects of running a practice, such as conducting quality assessment, auditing function, improvement activities, and customer service.

**APPOINTMENT REMINDERS:** Using voicemail, email, postcards, or letters.

**REQUIRED BY LAW:** In cases of abuse, neglect, for judicial proceedings, or to assist law enforcement officials.

**PUBLIC HEALTH:** Assist public health authorities to prevent or control disease, injury, or disability.

You have rights in respect to your child's protected health information, which is exercised by presenting a written request.

- You have the right to review a copy of your child's health information.
- The right to revoke your authorization to use or disclose health information except to the extent that action has already taken place.
- The right to receive an accounting of disclosures of protected health information.

If you feel that your rights to privacy have been violated, you may file a complaint to the U.S. Department of Health and Human Services (202) 619-0257.

Please read and sign that you acknowledge the receipt of the Notice of Privacy Practices.

| ___________________________________________ | _____________________ | _______________ |
|---|---|---|
| Signature of Child's Representative | Relationship | Date |

10587 Double R Blvd., #101
Reno, NV 89521

# STUDENT TEACHING ENVIRONMENT

**NOTICE:**
This notice is to alert you that part of our practice is a learning environment for college students. There will be times where students will be observing the therapy sessions with your child and/or interacting with them.

☐ I understand that college students will be observing/interacting with my child during some therapy sessions.

☐ I do NOT want college students observing/interacting with my child during any therapy sessions.

_______________________________________________
Child's Name

_______________________________________________
Parent/Guardian Name (printed)

_______________________________________________
Parent/Guardian Signature

_______________________________________________
Date

10587 Double R Blvd., #101
Reno, NV 89521

## AUTHORIZATION FOR RELEASE OF INFORMATION OR INDIVIDUAL ACCESS TO INFORMATION

I hereby authorize/request ___________________________________ to release/or grant me access to the patient information of:

____________________________________ ________________________________

Patient's Full Name Date of Birth

I request ONLY the following information to be released/accessed:

| | |
|---|---|
| ☐ Evaluation Reports<br>☐ Progress Notes<br>☐ Discharge Summary<br>☐ Phone Conference<br>☐ Email Contact | ☐ Emailing of Reports<br>☐ Insurance Correspondence<br>☐ Other (specify)_________________________<br>____________________________________________<br>____________________________________________ |

Release or Mail to ____________________________________________________________

____________________________________________________________

____________________________________________________________

**ATTENTION:** Once this information has been released to this Authorization, it may no longer be protected by Federal and/or State law/regulations and may no longer be deemed "Confidential". I permit the release of all information indicated above including test results and/or diagnosis and treatment information, if any, concerning drug/alcohol treatment or use, psychiatric treatment, or AIDS/HIV and other communicable diseases.

I understand that neither healthcare provider nor any of its affiliated healthcare providers can make me sign this Authorization as a condition in getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the federal Privacy Regulations allow it. I agree that I may receive a signed copy of this Authorization if I chose to do so.

I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will expire one-hundred-eighty (180) days from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I must mail, fax, or bring a letter in person stating that I want to cancel/revoke this Authorization. I understand that I mail, fax, or bring the letter to the address or fax number noted at the top of this page.

If you are signing on behalf of a patient for whom you are the legal guardian or personal representative, you must attach a certified copy of your appointment as a legal guardian or personal representative. If you are signing on behalf of a patient who is deceased, you must attach a certified copy of the patient's death certificate if the patient did not expire in the facility the information is requested from.

**NOTE:** Records will be mailed to above address unless otherwise noted.

_______________________________________________________________ ____________________

Signature of Patient/Legal Guardian/Personal Representative Date

_______________________________________________________________ ____________________

If someone else signs on behalf of patient, state your relationship to the patient Date