Pediatric Therapies of Savannah

532 Stephenson Ave., Suite 100 • Savannah, GA 31405 • Phone (912) 354-4474 • Fax (912) 354-4443

Please select the clinician(s) your child will be seeing:

Physical Therapists:
☐Paula Green, PT
☐Wanda Lowery, PT

Occupational Therapists:
☐Jane Yaklin, OTR/L
(J&K Therapy, Inc.)

Speech Language Pathologists:
☐Becky Brown, CCC-SLP
☐Anna Salter, CCC-SLP

Notice: "Pediatric Therapies of Savannah" is the name that we have given ourselves for the convenience of sharing office space, equipment, and a telephone number. None of us are partners with one another, nor are any of us employees of Pediatric Therapies of Savannah. Pediatric Therapies of Savannah has no partners, shareholders, employees, etc. There is no business relationship among us other that the arrangements that we each have made to share office space. Each of us within this office operates our own particular pediatric therapy separately and we are each independent contractors. You should not consider yourself to be a patient of anyone other than your assigned therapist at this location unless you have made separate arrangements with that person.

PATIENT INFORMATION

Child's Full Name: _____ Today's Date: _____

Diagnosis: _____ Date of Birth: _____/_____/_____ Sex: ☐Male ☐Female

Home Address: _____
Street City State Zip

Referring Physician: _____ Phone: _____ Primary Care Physician: _____ Phone: _____

PARENT/GUARDIAN INFORMATION

Mother/Guardian's Name: _____ Date of Birth: _____/_____/_____

Cell Phone: _____ Home Phone: _____ Email: _____

Home Address: _____
Street City State Zip

Father/ Guardian's Name: _____ Date of Birth: _____/_____/_____

Cell Phone: _____ Home Phone: _____ Email: _____

Home Address: _____
Street City State Zip

INSURANCE

PLEASE PROVIDE INSURANCE CARDS

Primary Insurance: _____ Policy #: _____ Group #: _____

Insured's Name: _____ Date of Birth: _____/_____/_____ Social Security #: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Insured's Name: _____ Date of Birth: _____/_____/_____ Social Security #: _____

If your child is covered by Georgia Medicaid, please indicate which program your child is enrolled in:

☐Deeming Waiver ☐SSI-Disability ☐Amerigroup ☐WellCare ☐Other: _____

ASSIGNMENT OF BENEFITS:

I authorize release of medical information for _____(child's name) necessary for billing purposes and assign the payment of medical benefits be made directly to the therapist(s) for services rendered. I understand that I am responsible for any balance in excess of the benefits provided by my policy. I understand that by signing this statement and accepting treatment I agree to abide by these terms. I understand that it is my responsibility to be aware of precertification requirements and limitations of providers.

Parent/Guardian Signature: _____ Relationship: _____ Date: _____

FINANCIAL POLICY

Private Insurance: Individual practitioners will file your private insurance for you if you provide all the required information at the time services are rendered and agree to grant assignment of benefits to us. We will make every effort to gain pre-certification where needed; however, it remains your responsibility to make sure the pre-certification has been approved. Some insurance companies have contracts that reduce, limit or exclude payments to therapists who are not in network. It is your responsibility to know if your insurance has such contracts and with whom. You will receive a monthly statement of your balance. Customarily we have waited until the insurance company has responded to the first set of bills submitted before expecting payment. At that time we will establish a payment plan for those charges, which are left unpaid. Any balances for charges that are not covered are your responsibility and you will be expected to continue making payments until the balance is paid in full. In the event your insurance company does not make payment within 45 days of our billing, you may at our discretion be expected to begin payment on the account.

Medicaid, Peach Care or Deming Waiver: If your child receives services through Medicaid, Peach Care or Deming Waiver you must provide a Medicaid card. Please be reminded that Medicaid provides for a limited number of treatments of each therapy per month. If you have given any other agency or school permission to bill Medicaid, it may affect our ability to receive payment and could result in dismissal from treatment.

Self-Pay: We understand you are in a particularly difficult position and want to ensure that your child receives the treatment he/she needs. We will work with you to establish a reasonable payment plan so that lack of insurance does not prevent your child from receiving the therapy he/she needs. Still you will be held accountable for your financial agreement.

Collection Proceedings: I hereby agree that if I fail to make monthly payments once notified of my balance, rebilling charges may be added to my bill for each monthly statement I fail to respond with a payment. If my therapist(s) deems it necessary to place my account with a collection agency, their collection fees may be added to my balance. Typically these range from 25-30% of the total bill.

Parent/Guardian Signature: _____ Relationship: _____ Date: _____

MEDICAL HISTORY

Child's Name: _____Diagnosis: _____ Age: _____ Height: _____ Weight: _____

Birth History:

☐Full-Term ☐Premature_____weeks Any complications? _____

Developmental History:

Please list in months when the following occurred:

Held up head_____	Rolled_____	Sat alone_____	Crawl_____	Smile_____	Babble_____	Pull up_____
Potty trained_____	Stood alone_____	First words_____	Walk_____	Give on request_____	Scribble_____	Bang objects together_____
Drink from a cup_____	Finger Feed_____	Chew meat_____	Run_____	Spoon feed self_____	Grasp rattle_____	

Please describe your concerns about your child's development: _____

Check any of the following that apply to your child:

☐Chronic illness	☐Chronic infections	☐Diabetes	☐Difficulty eating	☐Physical injuries	☐Meningitis	☐High Fever
☐Sight problems	☐Hearing problems	☐Heart defect	☐Recurrent hospitalizations	☐Mumps	☐Measles	☐Chicken Pox
☐Sleeping problems	☐Difficulty sleeping	☐Allergies	☐Lung/bronchial problems	☐Tuberculosis	☐Seizures	

Vision Tested? ☐Yes ☐No If yes, date of last hearing test & results: _____

Hearing Tested? ☐Yes ☐No If yes, date of last hearing test & results: _____

Does your child have a history of recurrent ear infections? ☐Yes ☐No Does your child have PE Tubes? ☐Yes ☐No Date(s): _____

Any known allergies? _____

Please list any other illnesses (other than typical childhood illnesses) hospitalizations, surgeries, & diagnostic testing: _____

_____

Please list other physicians and specialists who provide care to your child:

Name	Specialty

Current Medications:

Name	Dosage	Frequency	Reason for Medication

Equipment (Check all that your child has):

☐Splint	☐Walker	☐Bath chair	☐Glasses	☐TLSO	☐Adaptive seating
☐Braces	☐Cane	☐Prone Stander	☐Wheel Chair	☐Hearing aide	☐Other: _____

Feeding (Check any of the following that you have observed):

☐Food falling out of mouth	☐Difficulty chewing meats	☐Putting too much food in mouth at one time	☐Food aversion/refusal
☐Unable to drink without spilling	☐Picky eater	☐Coughing/ choking on certain foods. Please list: _____	☐History of aspiration—Date of most recent swallow study: _____

Social/Emotional History:

Who lives in your home? _____

What upsets your child? _____

What calms/soothes your child? _____

What are your child's favorite toys/activities? _____

What is your child's day/night sleeping schedule? _____

Education/Therapy Information:

Please list other therapies your child is receiving & where: _____

Is your child currently enrolled in Babies an't Wait (BCW)? ☐Yes ☐No If yes, which county? _____

Is your child currently enrolled in school? ☐Yes ☐No Where/what grade? _____

Does your child receive any therapy services through school? ☐Yes ☐No If yes, which service(s)? ☐PT ☐OT ☐ST

Does your child have a current Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP)? ☐Yes ☐No ***If YES and your child is covered by Georgia Medicaid or Tricare, please provide a copy of your child's IEP or IFSP which is required for Medicaid Prior Authorization.***

CONSENT FOR TREATMENT

I, knowing that _____ (child's name) has a diagnosis requiring occupational, physical, and/or speech therapy, voluntarily consent to such care deemed beneficial by the clinician's professional judgment for the aforementioned child by the clinician(s) I selected on page 1.

I am aware that the practice of occupational/physical/speech therapy is not an exact science and I acknowledge that no guarantee has been made to me as to the effect of occupational/physical/speech therapy treatment for my child.

Parent/Guardian Signature: _____ Relationship: _____Date: _____

NOTICE OF PRIVACY PRACTICES

I authorize Pediatric Therapies of Savannah to obtain or release any medical information necessary to provide medical services to me and/or to process insurance claims. In addition, I authorize Pediatric Therapies of Savannah to release any of my medical information that is required for any health care related utilization review, quality assurance activities or other healthcare operations. I understand medical information to be disclosed may include history, evaluation reports, consultation reports, progress notes, and discharge summaries.

I am aware that the following information may be disclosed for the following reasons:

- Medical information may be disclosed to appropriate authorities if there is reasonable belief that you are a victim of abuse or neglect or possible victim of other crimes.
- Medical information may be disclosed in response to a court or administrative order, subpoena, discovery request, or other lawful process.
- Medical information may be disclosed to an agency providing health oversight for activities authorized by law such as licensure or disciplinary actions, or other authorized activities. I understand I have the following rights:
- To request confidential communications of child's information.
- To copy and inspect components of my child's information that PTS obtains.

You may be charged a fee for copying and postage. I understand this consent may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Excluding revocation, this consent shall remain in effect as long as my child is a patient of Pediatric Therapies of Savannah. A photocopy of this consent shall be considered as effective and valid as the original. I understand I have the right to receive a copy of this consent. I acknowledge that I have received a detailed copy of Notice of Privacy practices which outlines in detail how medical information may be used and disclosed as well as how I might obtain an explanation as to what entities my information has been released. Below is a list of names of any family members, friends, and significant others who may receive information concerning my child's therapy:

Name: _____ Relationship: _____ Name: _____ Relationship: _____

Name: _____ Relationship: _____ Name: _____ Relationship: _____

Parent/Guardian Signature: _____Relationship: _____Date: _____

RELEASE/ACCEPTANCE OF INFORMATION

I hereby authorize the undersigned clinician/s to release to and accept from my Insurance Companies and/or any other medical providers involved in my child's care only such therapeutic and financial information as may be necessary to determine benefits entitled and to process payment claims for therapy services that will be provided. I hereby authorize the undersigned clinicians to release to and accept from attending physicians, therapists, teachers/school professionals therapeutic and financial information as may be necessary to coordinate my child's therapy plan of care. I understand that this release will be in effect until my child's chart is closed or until this consent is amended in writing.

Parent/Guardian Signature: _____Relationship: _____Date: _____

PERMISSION TO PHOTOGRAPH

I grant permission to the treating clinicians to record, photograph and/or videotape my child. I understand that the media can be used for several purposes including therapeutic purposes of evaluation, comparative studies to determine progress, training, and education, marketing and website. I agree to the following:

Education: ☐Yes ☐No Marketing: ☐Yes ☐No Social Media (Ex. Facebook): ☐Yes ☐No

Parent/Guardian Signature: _____Relationship: _____Date: _____

ATTENDANCE/SICK POLICY

In order to allow us to meet the needs of all the children at Pediatric Therapies of Savannah violation of our attendance policy may require the therapist to discharge your child from therapy and place him/her on the waiting list. Possible causes that may require a child to be discharged from therapy and placed on a waiting list:

1. Cancellation of 3 appointments with less than 24 hours notice in a 60-day period for ANY reason.
2. Missing an appointment 3 times in a 60-day period without notice or contact to Pediatric Therapies of Savannah.
3. 5 or more cancellations for any reason in a 60-day period.

If you miss 3 consecutive appointments without notice or contact with Pediatric Therapies of Savannah your child will be discharged from therapy. Please call the office as soon as you realize that your child will not attend therapy. You may leave a message on voicemail 24 hours a day.

Parents are expected to arrive on time for all appointments. Children that arrive 15 or more minutes late may not be seen for therapy. In order to respect the appointments scheduled after your child's therapy, we require that you pick your child up on time – please arrive 10 minutes prior to the end of the scheduled therapy time.

In order to maintain the health of the therapist and other children please do not bring you child if they have a fever or have experienced symptoms that are contagious (i.e. diarrhea, vomiting etc.) within a 24-hour period. If your child shows visible signs of illness, their appointment may be cancelled at the therapist's discretion.

Parent/Guardian Signature: _____Relationship: _____Date: _____

Send to Paula | Send to Wanda | Send to Jane | Send to Becky | Send to Anna

Print Form