New Patient Registration Form

General Patient Information

Patient's Full Name: _____Today's Date: _____

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

Home Address: _____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 (if different than pt): _____City_____State_____Zip_____

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

Cell Phone: _____ Home Phone: _____ Email: _____

Home Address (if different than pt): _____City_____State_____Zip_____

Insurance

PLEASE PROVIDE INSURANCE CARDS

Primary Insurance: _____Policy #: _____Group #: _____

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

Secondary Insurance: _____Policy #: _____Group #: _____

Policyholder'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 ☐ Peach State ☐ Caresource ☐ Other: _____

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:

(PT) Held up head_____	Rolled over_____	Sat alone_____	Crawl_____	Stood alone____	Walk_____
(ST) Smile _____	Babble ____	First words _____			
(OT) Grasp Rattle_____	Finger Feed _____	Spoon-fed self ____	Toilet-trained___		
(Feeding) Transition to cup____	Puree to soft solids_____				

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Please describe your concerns about your child's development:

_____

Check any of the following that apply to your child:

☐Chronic illness/ infection	☐ Recurrent hospitalizations	☐ Vision impairment	☐ Hearing impairment	☐Recurrent ear infections	☐PE Tubes Date: _____	☐High Fever
☐ Seizures	☐Diabetes	☐Heart condition	☐ Lung problems	☐Tuberculosis	☐Meningitis	
☐Sleeping problems	☐ Difficulty eating	☐Allergies	☐Asthma	☐Reflux		

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

_____

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

_____

Does your child have any known allergies?

_____

Please list any other illnesses (other than typical childhood illnesses) diagnoses, or conditions: ☐ or see attached list for additional information

_____

Please list any other hospitalizations or surgeries and corresponding dates: ☐ or see attached list for additional information

_____

Please list other physicians and specialists who provide care to your child: ☐See attached list for additional team members

Name	Specialty

Current Medications (including prescription and over-the-counter: ☐See attached list for additional 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 aid(s)	☐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: _____

Other History:

Who lives in your home?_____ What are your child's favorite toys/activities?_____

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

What calms/soothes your child?_____

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

Is your child receiving any other therapies ☐Yes ☐No If yes, where?_____

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

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 you answered "YES" to any of the above, please provide a finalized/signed copy of your child's IEP or IFSP as this document is often required for prior authorization before beginning treatment.

Assignment of Benefits/ Privacy Practices/Treatment Consent

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 Coastal Pediatric Therapies and its affiliates (Anna F. Salter, LLC, J&K Therapy, Inc. (Jane Yaklin), Paula Green, and Rebecca S. Brown Rehab and Consulting, Inc.). I understand that I am responsible for any balance in excess of the benefits provided by my policy. I understand that by signing below 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. **Initial here: _____**

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Receipt of Notice of Privacy Practices:

I, _____ (*print name*) certify that I am the parent/legal guardian of the child named above and hereby acknowledge receipt of a detailed copy of Coastal Pediatric Therapies' 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. I have read and understand Coastal Pediatric Therapies' Notice of Privacy Practices and may request a copy by mail or in person at any time. **Initial here: _____**

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. 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. **Initial here: _____**

Authorization to Release Medical Information:

Additionally, I authorize Coastal Pediatric Therapies, LLC and its said affiliates to obtain or release any medical information necessary to provide medical services to me and/or to process insurance claims. In addition, I authorize Coastal Pediatric Therapies 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 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 Coastal Pediatric Therapies and/or its said affiliates. 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.

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: _____

Responsible Party Signature: _____ Relationship: _____ Date: _____

Responsible Party Printed Name: _____

FINANCIAL POLICY

Private Insurance: We 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 the treating therapist(s). 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. Please note all copays are due at the time of service.

Medicaid, and any related Care Management Organization: If your child receives services through Medicaid, Deeming Waiver, Amerigroup, Caresource, Peachstate, or WellCare 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.

Babies Can't Wait: If you're child has participated in a Babies Can't Wait evaluation previously, it is your responsibility to let the front office and/or your therapist know. You will be responsible for any charges incurred if your evaluation is not approved.

Self-Pay: We will work with you to establish a reasonable payment plan so that lack of insurance coverage does not prevent your child from receiving the therapy he/she needs; however, 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.

Responsible Party Signature: _____ Relationship:_____ Date: _____

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Patient Name: _____ Date:_____

COASTAL PEDIATRIC THERAPIES, LLC and its said affiliates participate in clinical education programs with area colleges and universities to give students engaged in a course of study related to therapeutic practices experience in clinical practice. Your speech-language pathologist, occupational therapist, and/or physical therapist has agreed to permit these students to observe and participate in patient care activities, including, where appropriate, providing therapy service to patients under the clinician's direct supervision (e.g., in an approved clinical practicum).

By signing below, you agree to permit students shadowing/working with your child's therapist to observe your therapy sessions, including, where appropriate, providing direct treatment under your clinician's direct supervision. Participation is voluntary and you are not required to sign this consent form in order to receive treatment. You have the opportunity to refuse to give such consent and you may withdraw your consent at any time during your appointment.

_____I hereby give my consent for student observations/internships during my therapy sessions at **COASTAL PEDIATRIC THERAPIES, LLC**. I understand that at any time I can revoke my consent for participation.

_____ I decline to give consent to student observations/internships during my therapy sessions at **COASTAL PEDIATRIC THERAPIES, LLC**. I understand that declining will not impact the quality of speech therapy services that my child receives.

Signature of client: _____
Printed Name of Client: _____
Date: _____
Witness Signature: _____

If the client is a minor, please complete the following:

The client, _____, is a minor,____years of age: I hereby execute this document on the client's behalf. I have read and fully understand each part of this document. I represent and verify that I am authorized to execute this document on behalf of the client named above. I understand that I am entitled to receive a signed copy of this document.

Signature of parent, guardian, or legal representative of child: _____

Printed name of parent, guardian, or legal representative of child: _____

Date: _____

Witness Signature: _____

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Acknowledgement and Release

The undersigned parent or guardian acknowledges that, during therapy sessions, **Coastal Pediatric Therapies and its said affiliates** may photograph and/or video and audio record _____ (the "Patient"). The images and recordings may be used for formulating treatment plans and objectives and assisting in professional education, teaching, and data collection. The images and recordings may be shared with other patients for the foregoing purposes. Under no circumstances will the Patient's personal identifying information be shared or disclosed.

_____ Initials	The undersigned hereby consents, on behalf of the Patient, to such photography and recordings for the uses and purposes described above.

_____ Initials	The undersigned further consents, on behalf of the patient, to **Coastal Pediatric Therapies' and its said affiliates** use of such photography and recordings for marketing or promotional purposes in **Coastal Pediatric Therapies' and its said affiliates** web and print marketing and grants **Coastal Pediatric Therapies and its said affiliates** and its successors and assigns permission to copyright, use, reproduce, and publish the images and recordings, without compensation.

Signed by: _____

Printed name: _____

Relationship to Patient: _____

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RELEASE FOR APPOINTMENT REMINDERS

I, _____ (Print), hereby authorize **Coastal Pediatric Therapies and its said affiliates** to send me an appointment reminder via email or text message using the following information.

Email reminders may contain patient or clinic information such as, but not limited to, patient first name and clinic location.

Patient/ Guardian Contact Information:

(Please print clearly and legibly)

Email: _____

Cell phone: _____

Patient/ Guardian (Print): _____

Signature: _____

Date: _____

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NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used.
HIPAA provides penalties for covered entities that misuse personal 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.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing speech and language services by one or more speech-language pathologists. We may also share medical information with the patient's physicians.
- **Payment** means obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. However, we will only disclose medical information that these people need to know.

We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state, or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

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 action relying on your authorization.

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PRIVACY RIGHTS

Restricted Use and Disclosure: You may request that **Coastal Pediatric Therapies** not provide PROTECTED HEALTH INFORMATION to certain people including family members or relative. However, we are not required to agree to a requested restriction.

Confidentiality: You may request that **Coastal Pediatric Therapies** provide your health information in a confidential manner. You can request that we send your appointment cards, reports, bills and other mailings to a different address or that we notify you of this kind of information in another way, such as by telephone.

You must make this request in writing and specify another address or means of communication.

Inspection and Copy: You may ask to see and copy your speech and language, physical therapy (PT), or occupational therapy (OT) records unless that information is protected by law. You must make this request in writing. We will act upon your request within 30 days and may charge you a legally acceptable amount for copying costs. Records are maintained for six years from the date of service. Requests for any records older than six years may be denied.

Amend Speech & Language, PT, And OT Records: You may ask us to change information in the speech & language record. If your request is denied, you can write a Statement of Disagreement with the denial that we will keep in your chart.

Accounting of Disclosures: You may ask us to provide you with information about disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and healthcare operations. Requests for accountings will not be made prior to April 14, 2003. Your request can go back six (6) years after April 14, 2008.

Paper Copy: You may request a paper copy of this notice if you received this notice electronically.

Privacy Violations: We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with this notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION is required to abide by the terms of the Privacy Practices Notice currently in effect. We reserve the right to change the terms of this Privacy Practices Notice and to make new notice provisions effective for all PROTECTED HEALTH INFORMATION maintained by **Coastal Pediatric Therapies.** If the terms of this notice are changed, we will provide you with a revised version at the time of treatment or upon request.

If you feel your privacy rights have been violated, you may file a complaint with the Department of Health and Human Services, Office of Civil Rights and/or with **Coastal Pediatric Therapies**' office. Filing a complaint will not affect the quality of the services you receive from **Coastal Pediatric Therapies**, and you will not be retaliated against for filing a complaint.

The U.S. Department of Health & Human Services
Office of Civil Rights
2000 Independence Avenue S.W.
Washington, D.C. 20201
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