

THE CHILDREN'S THERAPY CENTER

PATIENT REGISTRATION – Please Print Clearly

PATIENT NAME First Middle Last		SEX • M • F	DATE OF BIRTH	AGE
HOME ADDRESS		CITY	STATE	ZIP CODE
FATHER'S NAME First Middle Last		FATHER'S SSN	MARITAL STATUS ' M ' D ' S	
FATHER'S OCCUPATION/ EMPLOYER	FATHER'S CELL PHONE	WORK PHONE	HOME PHONE	
MOTHER'S NAME First Middle Last		MOTHER'S SSN	MARITAL STATUS ' M ' D ' S	
MOTHER'S OCCUPATION/EMPLOYER	MOTHER'S CELL PHONE	WORK PHONE	HOME PHONE	
PRIMARY CARE PHYSICIAN/GROUP	PCP ADDRESS	FAMILY E-MAIL ADDRESS		

BILLING AND INSURANCE INFORMATION

SEND MONTHLY STATEMENT TO:	<ul style="list-style-type: none"> • PARENTS AT ABOVE LISTED HOME ADDRESS 			
	NAME	RELATIONSHIP TO PATIENT	PHONE	
	ADDRESS			
PRIMARY INSURANCE	INSURANCE COMPANY NAME		PRIMARY SUBSCRIBER	DATE OF BIRTH
	GROUP NUMBER	ID or POLICY NUMBER	Social Security # of Insured - -	
	CLAIMS ADDRESS			MEMBER SERVICE PHONE #

PARENT SIGNATURE

TODAY'S DATE

(PLEASE CAREFULLY READ AND SIGN ALL 5 PAGES)

THE CHILDREN'S THERAPY CENTER, P.C.

FINANCIAL AGREEMENT

Please Read Carefully

I, _____ hereby authorize the release of any information requested by my insurance company and authorize payment by my insurance of medical benefits to The Children's Therapy Center. I agree to be ultimately responsible for payment of all charges for services rendered by The Children's Therapy Center whether or not such services are covered by insurance benefits and am fully responsible for the designated co-pay, and for full payment of orthopedic appliances and custom orthotics. I agree to reimburse The Children's Therapy Center for any expenses, including reasonable attorney's fee, incurred in connection with the collection of sums due for services preformed hereunder.

I _____ understand that any Insurance balance 90+days overdue, is the immediate responsibility of the family.

I _____ will cancel appointments within 24 hours of the scheduled appointment time, or be subject to the cancellation fee of \$25.

I _____ understand that therapy must be consistent in order to be beneficial and frequent cancellations may result in the loss of my child's regularly scheduled appointment time.

Signature, Parent/Guardian

Date

THE CHILDREN'S THERAPY CENTER, P.C.

CONSENT TO RELEASE FORM

I, _____, am signing this for
(Full printed name of consenting guardian)

_____ (Full printed name of child) _____ (Date of birth)

The Children's Therapy Center is authorized to share medical information with the physicians and providers listed below:

<u>Provider Name</u>	<u>Address/Phone#</u>	<u>Fax#</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I can withdraw this consent at any time by contacting The Children's Therapy Center.

Authorized Signature: _____ Date: _____

THE CHILDREN'S THERAPY CENTER, P.C.
DESCRIPTION OF SERVICES, POLICIES AND PROCEDURES

This may be your first visit as a client to our practice. You should know that we will do our utmost to make this visit pleasant and beneficial for you and your child. We are dedicated to the optimum in patient care and welcome your suggestions and opinions.

Professional Philosophy

It is our desire to provide the highest quality of medical care to our patients and to do this in a professional and empathetic way. It is our intention to accomplish these goals through personalized care presented in a comfortable manner.

Financial Policy

It is your responsibility to provide us with complete insurance information before services begin. Billing your insurance carrier is a courtesy we extend to you. All charges are your responsibility as of the date of service. Any balance outstanding for **90 days** is the immediate responsibility of the parents or guardian. Please read the information below that applies to your insurance situation.

Coverage/Benefits/Authorization

Your insurance coverage depends on **your** contract with the insurance company. It is your responsibility to contact our office to insure that authorization for appointments has been obtained. You are bound by your plan to follow their rules and guidelines for obtaining a referral from your primary care physician before being seen in this office. Obtaining a referral is your responsibility and never the responsibility of this office. It is your responsibility to keep track of your referrals and the number of visits they authorize. Please note that an authorization is not a guarantee of payment by your insurance carrier. We are not responsible for notifying you when you are out of authorized visits. Please note that referrals cannot be dated retroactively after the date of service. You remain ultimately responsible for payment of all services. Our staff cannot be familiar with the requirements of all group plans since they can vary considerably within the same plan.

Services Not Medically Necessary

If your insurance company determines that our services are not medically necessary, you remain responsible for payment of those services.

Change of Insurance Plan

You must inform us of any change in your insurance carrier three days prior to receiving services under the new coverage. Payment for services without timely notification is your responsibility.

Usual and customary Rates (UCR)

We are under no obligation to accept arbitrary and usual and customary rates of insurance carriers for whom we are an out of network provider.

Self Pay

Parents with no health insurance coverage or those who prefer to bill insurance carriers themselves are expected to pay cash when services are provided. We accept VISA, Mastercard, Discover and American Express credit cards in addition to personal checks.

Co-insurance/Co-payments

Your portion of the payment as determined by your insurance, is payable before services are provided. Any check returned by the bank for lack of sufficient funds will incur a \$30 charge to your account.

Cancellations

We must be informed of broken appointments at least **24 hours** prior to the scheduled time. Failure to do so will result in a charge of **\$25** to your account that is not billable to your insurance carrier.

Remember, therapy must be consistent to be beneficial.

Thank you for reading this policy. Insurance carriers' health care rules and benefits can be very confusing. Please let us know if you have any questions.

Signature of parent or guardian

Date

THE CHILDREN'S THERAPY CENTER
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES*

I, _____ have read the Notice of Privacy Practices.
(Please print full name)

Signature: _____

Date: _____

* Attachment: Privacy Practices

PROVIDER NOTICE OF PRIVACY PRACTICES

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

Uses and Disclosures: The Children's Therapy Center uses health information about you for treatment to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive at The Children's Therapy Center. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you.

Your Rights: In most cases, you have the right to review, or get a copy of, health information about you. If you request copies, The Children's Therapy Center will charge you only normal photocopy fees. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

Our Legal Duty: We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints: If you are concerned that The Children's Therapy Center has violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions, or complaints, please contact
Owner/Administrator: Susan Syron, P.T.
Address: 8348 Traford Lane, Suite 200
Springfield, VA. 22152
Phone: 703-569-7500

Uses and Disclosures of Protected Health Information

Following are examples of the types of uses and disclosures of your protected health care information that the provider is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures.

Treatment: The Children's Therapy Center will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, your protected health information may be provided to a doctor to whom you have been referred to ensure that the doctor has necessary information to diagnose or treat you.

Payment: Your protected health information will be used by The Children's Therapy Center, as needed, in activities related to obtaining payment for your health care services. For example, obtaining information from your specialist or other physicians, may be required, or sending relevant protected health information to specific professionals may be disclosed so that accurate and complete information can be sent to your health insurance company to obtain approval for treatment.

Healthcare Operations: The Children's Therapy Center may use or disclose, as needed, your protected health information in order to support our business activities. For example, when we review employee performances, we may need to look at what an employee has documented in your medical record.

Business Associates: The Children's Therapy Center will share your protected health information with third party business associates that perform various activities (billing, transcription, fabrication of braces, hand splints, other medical equipment). Whenever an arrangement between us and a business associate involves the use or disclosure of your protected health information, we will have a written contract with that business associate that contains terms that will protect the privacy of your protected health information.

Marketing: The Children's Therapy Center may use or disclose certain health information in the course of providing you with information about treatment alternatives, health related services, or fundraising. You may contact us to request that these materials not be sent to you.

Written Authorization: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing.

Opportunity to Object: We may use and disclose your protected health information in the following instances. You have the right to object. If you are present or able to object, then your provider may, using professional judgment, determine whether the disclosure is in the best interest.

Facility Directories: Unless you object, The Children's Therapy Center will use and disclose our facility directory, your name, the location at which you are receiving care, your address, and your phone number. All this information will be disclosed to only The Children's Therapy Center staff for their use in communicating with you for professional reasons. The information will not be used for any marketing, information sharing with other agencies, or personal use.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care.

Emergencies: In an emergency treatment situation, The Children's Therapy Center shall try to provide you a Notice of Privacy Practices as soon as reasonably practical after the delivery of treatment.

Without Opportunity to Object: The Children's Therapy Center may use or disclose your protected health information in the following situations without your authorization or opportunity to object:

Public Health: Information disclosed for public health purposes to a public health authority or to a person who is at risk of contracting or spreading a disease.

Health Oversight: Information disclosed to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Abuse or Neglect: Information disclosed to an appropriate authority to report child abuse or neglect, if we believe that you have been victim of abuse, neglect or domestic violence.

Legal Proceeding: Information disclosed in the course of legal proceedings.

Law Enforcement: Information disclosed for law enforcement purposes, such as pertaining to victims of a crime or to prevent a crime.

Research: Information disclosed to researchers when their research has been approved by an Institutional Review Board.

Worker's Compensation: Information disclosed to comply with worker's compensation laws.

Compliance: Information disclosed to The Department of Health and Human Services to investigate our compliance.

In general, we may use or disclose your protected health information as required by law and limited to the relevant requirements of the law.

Your Rights:

You Have The Right To:

Inspect and copy your protected health information. However, The Children's Therapy Center may refuse to provide access to certain psychotherapy notes or information for a civil or criminal proceeding.

Request a restriction of your protected health information. You may ask The Children's Therapy Center not to use or disclose certain parts of your protected health information for treatment, payment or healthcare operations. You may also request that information not be disclosed to family members or friends who may be involved with your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request, but if we do agree, then we must behave accordingly.

Request to receive confidential communications from The Children's Therapy Center by alternative means, or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis of your request.

Ask The Children's Therapy Center to amend your protected health information. You may request an amendment of protected health information about yourself. If we deny your request or amendment, you have the right to file a statement of disagreement with us, and your medical record will note the disputed information.

Receive an accounting or certain disclosures that The Children's Therapy Center has made. This right applies to disclosures for purposes other than treatment, payment or healthcare operations. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your case, or for notification purposes. You have the right to receive specific information regarding these disclosures. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

ACCOUNTING AND RESTRICTIONS POLICY

ACCOUNTING OF DISCLOSURES

The patient may have a right to receive an accounting of certain disclosures of the patient's protected health information. The patient's request may occur in writing or verbally and The Children's Therapy Center will record the request in our communication log or in the comments section of our billing software. We have 60 days to respond. Our accounting to the patient will:

- Be in writing
- Include the dates of disclosure and to whom the information was sent
- Describe what information was sent
- State the purpose of the disclosure

Disclosures that may be tracked:

- Treatment, payment, or health care operations
- Any information that is made with patient authorization
- Any information covered by a business associate agreement
- Any information required for national security
- Any information required for correctional institutions