Pediatric Therapy Center

10601 S. 72nd Street, Suite 103
Papillion, Nebraska 68046
402-932-2782
Fax 402-932-2705
www.ptcne.org

EMPOWERING CHILDREN, FAMILIES AND OUR COMMUNITY.

Welcome to Pediatric Therapy Center, PC!

We appreciate the opportunity to work with you and your child. Please read through and complete all paperwork before your arrival. We ask that you please arrive 15 minutes prior to the start of your appointment. We also ask that siblings not attend the evaluation appointment due to the length of the appointment and so as not to distract from any testing that may need to be administered.
Use the checklist below to ensure all necessary forms have been completed and reviewed. After completion of this packet, please sign below and return to Pediatric Therapy Center at the time of your evaluation.

Thank you for choosing Pediatric Therapy Center. We look forward to working with you and your family.

This packet includes the following:

- General Info, School Info, Development & General Health, Milestones (Pages 2-3)
- Food Permission Info, Video & Picture Release, & Consent to Release Info (Page 4)
- Attendance Policy & Drop Off Policy (Page 5) **(For your records)**
- Parent Attendance, Sick Policy, Financial Policy, Child Abuse, & Judicial Policies (Pages 6-8) **(For your records)**

My signature below is confirmation I have read and received all necessary paperwork and I agree to all terms and conditions. I have informed PTC of all necessary information regarding my child's health and give permission to the therapists at PTC to treat my child at their discretion.
I have provided PTC with my insurance information and acknowledge I am financially responsible for all charges not paid by insurance. This also authorizes PTC to release all information necessary to secure the payment of benefits.

_____
Child's Name

_____ _____
Parent/Guardian Signature Date

*****TO BE SIGNED IN OFFICE*****
I have received and understand PTCs Notice of Privacy Policies and Practices.

_____ _____
Parent/Guardian Signature Date

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General Information

Child's Name: _____ Date of Birth: _____

Address: _____ City: _____State: _____ Zip: _____

Parent/Guardian Names: _____

Work Phone: Mom: _____ Dad: _____

Cell Phone: Mom: _____ Dad: _____

Home Phone: _____Parent Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about us? _____

School Information

Name of School:_____ Current Grade:_____

Teachers Name:_____ Academic Concerns:_____

_____

Does your child currently receive school based services? YES NO If so, please provide types of therapy and frequency:

_____

Development and General Health

Was your child born before 37 weeks?	NO	YES. Please specify:
Did your child spend time in the NICU?	NO	YES. Please specify:
Did your child require special treatment after birth? (i.e oxygen, jaundice, etc.)	NO	YES. Please specify:
Does your child have a medical diagnosis?	NO	YES. Please specify:

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Child's Name: _____

Does your child currently take any medications?	NO	YES. Please specify:
Has your child experienced any major injuries or hospitalizations?	NO	YES. Please specify:
Has your child had problems with his/her ears or hearing?	NO	YES. Please specify:
Does your child wear glasses?	NO	YES.
Has your child had or is he/she currently scheduled for any additional tests regarding their chief complaint(s)? (MRI, swallow study, hearing test, etc)	NO	YES. Please specify:
Does your child have a history of seizures?	NO	YES. Please comment:
Has your child received any therapy services in the past?	NO	YES. Please specify:

Milestones
(To be completed if your child is age 3 or younger)
Give approximate age if remembered, or comment on anything unusual

Rolled over_____ Sat alone _____

Crawled _____ Walked_____

Chewed food_____ Drank from a cup_____

Said words_____ Said sentences_____

Finger fed_____ Used utensils_____

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Child's Name: _____

Food Permission/Dietary Information

Please list any allergies or sensitivities your child may have, including food, non-food, and/or latex:

_____

_____

Please complete the following to allow your child to participate in snack activities.

_____ My child may participate in snacks and has no diet restrictions.

_____ My child may participate in snacks if diet restrictions are observed.

Diet Restrictions:_____

_____ My child should **not** participate in snack time, unless the snack is provided by myself.

Video and Picture Release

_____ I give permission for my child's picture/video to be used by Pediatric Therapy Center, P.C. for the purpose of training other professionals or paraprofessionals.
_____ I give permission for my child's picture/video to be used by Pediatric Therapy Center, P.C for marketing/publicity.
_____ I do not wish my child's picture/video to be used for any purpose other than training his/her specific clinical team.

Consent to Release/Receive Medical Information

We encourage you to provide us with contact information of other professional(s) working with your child, so we may coordinate care.
I agree to let Pediatric Therapy Center, P.C. share and receive information from other agencies (organizations) about my child so services can be coordinated and optimized for my child's benefit. The following organizations are included in this release:

Medical Professionals: _____

Schools/Teachers: _____

Other:_____

Parent Signature:_____

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PLEASE KEEP FOR YOUR RECORDS

Cancellation and Sick Policy

Pediatric Therapy Center does NOT currently charge a fee for missed appointments or last minute cancellations. To avoid moving to this type of policy we ask for your help by adhering to our current policy:

- Whenever possible we ask for a 24 hour advanced notice when cancelling an appointment.
- A "NO SHOW" is any appointment missed without notification of cancellation OR any appointment cancelled with less than 24 hours notice.
    - Patients are only allowed 3 "no shows" (as defined above) in a 60 day period, or 5 cancellations (regardless of the reason) in a 60 day period.
    - Any patient reaching the maximum number of "no shows" or missed appointments will be notified, and be placed on attendance probation.
- Terms of attendance probation:
    - All scheduled appointments will be cancelled.
    - Appointments may only be scheduled on Monday of the current week.
    - The probation period will last a minimum of 4 weeks.
    - Additional attendance problems may result in an extended probation period or in discharge from all therapy services.

This attendance policy is in place to prevent last minute cancellations due to scheduling conflicts. However, to maintain the health of the staff and patients, a separate policy is in place regarding cancellations due to illness:

- Do NOT bring your child if they have had a fever or experienced other symptoms that are contagious, within a 24-hour period. Please call our office as soon as you know your child will not be able to attend their appointment.
- If your child shows visible signs of illness during a therapy session, their appointment may be rescheduled at the discretion of PTC staff.

Drop Off Policy

- Parents are expected to be on time for arrival and pick up of their children for appointments.
- Children that arrive **10 or more minutes late** for an appointment will be rescheduled as appointments are available.
- We request you be available **10 minutes PRIOR** to the end of your child's therapy session so the staff may talk with you and educate you on any home programming needs. If you are unavailable 10 minutes prior to the end of the treatment session, or arrive late to pick up your child, the staff may not be able to address your home program needs or answer any questions.
- You may leave the premises of PTC during treatment sessions as long as you can be reached by cell phone at all times. If you do not have a cell phone we require you remain on the premises.

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Sibling/Parent Attendance Policy

It is the policy of PTC that siblings will not be allowed in the gym area during treatment sessions. We encourage parental involvement, and parents are welcome to observe therapy sessions. We request only one parent/caregiver be present at a time during therapy sessions. If parent/caregiver attendance is a distraction or impacts any child's participation you may be asked to sit out of sight or to wait in the waiting room to optimize the effectiveness of the treatment session.

Financial Policy

Insurance

Insurance claims will be filed on the next business day by our billing vendor. Your insurance company may request certain information directly from you, and it is your responsibility to comply with their requests. Additionally, your insurance company may request clinical information about your child from PTC. It is our policy to release such information to assist you in the filing of your insurance claims.

Once claims have been processed, it is your responsibility to pay the balance of any uncovered claims and/or any balances unpaid by the insurance company. Your insurance benefits are a contract between you and the insurance carrier; PTC is not a party to that contract. In the event of a denied claim(s), or if PTC is not in network with your insurance plan, PTC will offer a 20% discount for services.

Please make sure we receive a copy of your insurance card and/or ID when you arrive at your first visit and/or if you receive a new card or change insurance plans after your first visit. If you fail to provide this information in a timely manner, you may be responsible for the balance of the claim(s). PTC will file claims with up to two insurances companies on your behalf; you will be responsible for filing any additional claims. PTC staff will verify your insurance coverage before your initial evaluation and can inform you of your child's benefits. **This is not a guarantee of benefits or payment.** We also strongly encourage you to call your insurance company directly to get an explanation of benefits and to make sure all information is understood and accurate. Some services a patient receives at PTC may be non-covered or deemed not medically necessary by your insurer. Patients may be billed for such services if applicable.

Co-payments and Deductible

All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on the part of PTC staff to collect co-payments from patients can be considered fraud. **If you have an insurance co-payment it will be collected when you check in at each visit.**

Methods of Payment

PTC accepts payment by cash, check, Visa, MasterCard, Discover, and all Flex Spending Cards associated with one of these major credit cards. A $35.00 service fee will be added to all checks returned for insufficient funds. If your check is returned, you will be required to pre-pay all future services in full by cash, Visa, MasterCard, or Discover.

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Patient Statements
Unless other arrangements are approved by PTC in writing, all balances are due in full at the time the statement is issued, and are considered past due if not paid within 30 days.

Nonpayment
If your account is past due 90 days or greater, and a payment arrangement has not been made, the account will be sent to collections. Until such balance is paid in full, scheduling and attending therapy sessions will be on hold. Patients may be discharged from services due to non-payment.

Bankruptcy
In the event of bankruptcy, any future appointments would need to be paid at the time of service.

Divorce
In the case of a divorce or separation, both parties may be held responsible for any balances owed.

Credit Balance Refunds
Pediatric Therapy Center will make a good faith effort to capture all accounts which have been overpaid by a patient or insurance carrier and to refund the appropriate party within a reasonable time frame. Refunds will be issued quarterly via company check, payable to the patient or insurance carrier.

Self Pay
In the event a patient does not have health insurance coverage, a 20% cash discount will be applied to therapy services. A minimum of a $50 per therapy copay must be paid at the time of service and PTC will invoice the patient for all remaining charges.

Payment Plan
Payment plans will be considered on a case by case basis and must be arranged in advance with PTCs billing company.

Child Abuse
If PTC knows, or has reasonable cause to suspect that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare, the law requires such knowledge or suspicion to be reported to the proper authorities.

Legal Proceedings
By law, PTC is required to release information about your child's health information and services received at PTC when requested by subpoena or court order.