



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!**

Thank you for choosing Pediatric Therapy Center. 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.

**This packet includes the following:**

- General Info, School Info, Development & General Health (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: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Legal Guardian 1:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

**Legal Guardian 2:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

**Miscellaneous:**

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Plan 1: \_\_\_\_\_ Primary Insured: \_\_\_\_\_

Insurance Plan 2: \_\_\_\_\_ Primary Insured: \_\_\_\_\_

Is the child currently a ward of the state? **YES NO** If Yes, please list contact information:

Caseworker Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**School Information**

Name of School: \_\_\_\_\_ Current Grade: \_\_\_\_\_

Academic Concerns: \_\_\_\_\_

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

\_\_\_\_\_

**Development and General Health**



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

**Food Permission/Dietary Information**

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



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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, listed above, are observed.
- \_\_\_\_\_ My child should **not** participate in snack time.

**Video and Picture Release**

- \_\_\_\_\_ I give permission for my child's picture/video to be used by Pediatric Therapy Center, PC for the purpose of training other professionals and 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. Pediatric Therapy Center, PC will only release information to the primary care physician, legal guardian, and those listed below.  
*I agree to let Pediatric Therapy Center, PC share and receive information about my child so services can be coordinated and optimized for my child's benefit. The following are included in this release:*

- Medical Professionals: \_\_\_\_\_
- \_\_\_\_\_
- Schools/Teachers: \_\_\_\_\_
- Caseworker(s): \_\_\_\_\_
- Non-Guardian Family Members: \_\_\_\_\_
- Other: \_\_\_\_\_
- Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## **\*\*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 in a 90-day period.
  - Any patient reaching the maximum number of no shows will 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 for a period of 4 weeks.
  - Additional attendance problems may result in an extended probation period or in discharge from all services.
  - For families with multiple children attending therapy, please note that attendance probation will affect the entire family.

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, vomiting, 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.
  - Failure to call and cancel when a child is sick may still result in a no show.
- If your child shows visible signs of illness during a therapy session, their appointment may be rescheduled at the discretion of the staff.

### **Drop Off Policy**

- Parents are expected to be on time for arrival and pick up of their children for appointments.
- Children arriving **15 or more minutes late for an OT/PT** appointment will be rescheduled as appointments are available and the appointment will be marked as a no show.
- Children that arrive **10 or more minutes late for an SLP appointment** will be rescheduled as appointments are available and the appointment will be marked as a no show.
- 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 will 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.
- **PLEASE NOTE: You must remain on PTC premises if your child has a seizure disorder or an allergy known to cause anaphylaxis.**



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Failure to abide by the above policies could result in disciplinary action or a complete discharge from therapy services.

### **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**

Claims will be filed to your insurance company within 2 business days. 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 insurance companies on your behalf; you will be responsible for filing any additional claims. PTC staff will verify your insurance coverage before your initial evaluation; **this is not a guarantee of benefits or payment.** We strongly encourage parents to call the 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.

#### **Patient Statements**



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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. PTC may request a current copy of the divorce decree or custody agreement. In the event one responsible party defaults on a payment, the other party may be held financially responsible for the balance owed.

**Credit Balance Refunds**

PTC 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. Families will be expected to pay a copay amount between \$50-\$100 for each date of services, dependent on how many therapies are being performed. An invoice for the remaining amount will be mailed on a monthly basis. Families will be required to sign a Private Pay Agreement to receive the 20% discount.

**Payment Plan**

Payment plans will be considered on a case by case basis and must be arranged in advance with PTC's billing company. In no circumstance will a payment plan be allowed to go past 12 months. If a sufficient payment agreement cannot be reached, then PTC reserves the right to decrease or discontinue therapy services. Any missed payments will result in the account going immediately to collections and the cancellation of any previously scheduled appointments.

All patient balances are expected to be paid in full within 30 days upon receipt of a patient statement (unless a payment plan is set up). If full payment cannot be made, the following guidelines will be in place when setting up a scheduled payment agreement:

<b>Balance Owed</b>	<b>Minimum Monthly Payment</b>	<b>Payment Plan Duration</b>
\$250 or less	\$75 per month	4 months or less
\$251-\$500	\$125 per month	4 months or less



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\$501-\$1000	\$175 per month	6 months or less
\$1001 or greater	\$225 per month	12 months or less

- Payment plans must be set up in advance by contacting PTCs billing department at 402-390-6062.

If the insurance plan continues to process claims, increasing the patient/family balance, PTC reserves the right to adjust the minimum monthly payment based on the above terms. If at any time a payment is missed, or a family cannot commit to the monthly payment, PTC may decrease therapy frequency and, in some cases, put therapy on hold.

**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.