Coastal Kids Therapy

Patient Information Sheet **Please complete all information** Today's Date: _____

Child's Full Name :_____ Date of Birth:_____

Patient Demographics

Mother's Name:	Address:	Employer:
Cell Phone:	Home Phone:	Work Phone:
Mother's DOB (*required*):	Mother's SSN (*required*):	
Email Address:	Preferred Contact Method (circle one) Email Phone Call Text Message	
Father' s Name:	Address:	Employer:
Cell Phone:	Home Phone:	Work Phone:
Father's DOB (*required)*:	Father's SSN (*required*):	
Emergency Contact Name & Relationship:	Phone Number:	
Name of Current School:	Grade:	Current IEP?: Yes No

INSURANCE INFORMATION (PLEASE GIVE YOUR CARD TO THE RECEPTIONIST)

Person responsible for bill: Birthdate: Phone number:

Address (if different):

Medicaid (circle one): Yes No Medicaid #:

Primary Insurance Name:

Subscriber's Name: Subscriber's SSN: Birthdate:

Group #: Policy #: Co-pay amount: $_____

Patient's relationship to subscriber (circle one): Self Child Other

Secondary Insurance Name:

Subscriber's Name: Subscriber's SSN: Birthdate:

Group #: Policy #: Co-pay amount: $_____

Patient's relationship to subscriber (circle one): Self Child Other

Medical Information/History

Primary Physician:	**Secondary Physician** (any other physician reports should be sent to):
Diagnosis:	Date Diagnosed:
Present Medications:	

Birth Weight: pounds ounces	Complications With Delivery:	Weeks Gestation:
Surgeries:		

Does your child have any adaptive/medical equipment? ☐Yes ☐No
If yes, please explain.

Does your child follow any special diet or have feeding issues? ☐Yes ☐No
If yes, please explain.

Does your child have any allergies? ☐Yes ☐No
If yes, please explain.

Other Medical Concerns/Precautions:	**Please describe any family history of developmental or learning problems:**
Is your child <u>currently</u> receiving any other services? If so, where? ☐ OT _____ ☐ PT _____ ☐ ST _____ ☐ Psych/counseling _____ ☐ Other:_____	**Has your child ever received any type of therapy in the past?** ☐ OT ☐PT ☐ST ☐Psych/counseling ☐ Other:_____

Therapy Goals:
Please briefly describe your concerns and desired outcomes for your child during therapy sessions

<u>Occupational Therapy:</u>

Please enclose any other therapy evaluation and/or school reports you may have.

Your Rights as a Client

Each client of Coastal Kids Therapy has the following rights:

1. The right to be treated with consideration and respect for personal dignity, autonomy and privacy.
2. The right to receive services in the least restrictive, feasible environment.
3. The right to be informed of your child's condition.
4. The right to be informed of available services.
5. The right to give consent or to refuse any service, treatment or therapy
6. The right to participate in the development, review and revision of your child's individualized treatment plan and receive a copy of it.
7. The right of freedom from unnecessary physical restraint or seclusion.
8. The right to be advised and the right to refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, television, movies or photographs.
9. The right to confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of client information under NC state and federal laws and regulations.
10. The right to have access to one's own client record in accordance with program procedures.
11. The right to be informed of the reason(s) for terminating participation in a program.
12. The right to be informed of the reason(s) for denial of a service.
13. The right not to be discriminated against for receiving services on the basis of race, ethnicity, age, color, religion, sex, national origin, sexual orientation, socio-economic status, disability or HIV infection, whether asymptomatic or symptomatic, or AIDs.
14. The right to know the cost of services.
15. The right to be informed of all client rights.
16. The right to exercise one's own rights without reprisal.
17. The right to file a grievance in accordance with program procedures.
18. The right to have oral and written instructions concerning the procedure for filing a grievance.
19. The right to individualized treatment, including an adequate number of competent, qualified and experienced professional clinical staff to supervise and carry out the treatment or programs plan.
19. The right to exercise any and all rights without reprisal in any form including continual uncompromised access to services.
20. The right to contact Disability Rights NC, the statewide agency designated under federal and State law to protect and advocate the rights of persons with disabilities.

Any client who has reason to believe that he/she has been mistreated, denied services, or discriminated against in any aspect of services because of disability may file a grievance with the Owner: Laurel Thornton, 503 Covil Avenue, Suite 100 Wilmington, NC 28403. laurel@coastalkidstherapy.com

503 Covil Avenue, Suite 100
Wilmington, NC 28480
910-792-6706

Consent for Treatment

By signing below, this patient or legal guardian gives consent for evaluations, procedures and treatment as ordered by physician from Coastal Kids therapy and their treating therapists. With this consent, Coastal Kids Therapy PLLC may e-mail or call my home or other alternative location and leave a message on voice mail or in person, in reference to any items that assist in the practice in carrying out treatment, payment, and health care operations, such as appointment reminders, insurance items, and any calls pertaining to clinical care. This consent is valid from the date signed to the end of treatment sessions.

ACKNOWLEDGEMENT AND ASSUMPTION OF RISK: By signing below, I acknowledge and agree to have my child (or the child under my care), receive therapy services from Coastal Kids Therapy. I acknowledge that there is some risk inherent in the use of the therapy equipment during sessions and I agree to assume these risks and hold Coastal Kids Therapy and its staff, harmless from any and all losses and claims for any injuries or other damages occurring to myself, my child or our belongings.

EMERGENCY CARE: By signing below, I grant Coastal Kids Therapy permission to seek emergency care from a hospital or physician if there is a medical emergency or medical attention is required.

Acknowledgement of Privacy Notice and Client Rights

As a client of Coastal Kids therapy, you have certain rights regarding your child's services and the protection of your/your child's health care information. "Notice of Privacy Practices" has been given to you today. Providing your signature below means understanding that:

1) Any and all records, whether written, oral or electronic format, are confidential and cannot be disclosed for reasons outside of treatment or payment operations without prior authorization, except otherwise prohibited by law
2) A photocopy or fax of this consent is as valid as the original

_____

Print Child's Name Date of Birth Client/Parent/Legal Guardian Signature Date

Notice: This consent can be revoked at any time. Written requests can be sent to Laurel Thornton, owner at laurel@coastalkidstherapy.com or by phone: 910-792-6706

Authorization and Release

I authorize Coastal Kids Therapy PLLC to bill and receive payments from my insurance company. I also permit the necessary information, including medical records to my insurance company.

INITIALS _____

Attendance and Cancellation Policy

Due to the demand for services, appointments cancelled with less than 24 hours' notice will result in a cancellation fee of $30. Repeated cancellations may result in either forfeiture of permanent appointment or termination of service. Failure to contact the office prior to appointment time will be a no show and a no show fee of $30 be charged. Cancellation fees are not reimbursed by insurance companies or Medicaid and will be billed to the responsible party. If you miss 3 scheduled treatment sessions without notifying the treating therapist, treatment services may be terminated. I acknowledge that by initialing below, I have read the Attendance and Cancellation Policy, and I understand and agree to cooperate with the Cancellation Policy.

INITIALS _____

Teaching and Education of Students

Coastal Kids Therapy is a teaching facility. Students may be present and working with my child with supervision by therapist, upon occasion. I give permission for occupational, physical, and speech therapy students to observe my child's therapy sessions. If I object to a student working with my child, I will not initial this section.

INITIALS _____

Insurance Policy

Prior to the first visit, Coastal Kids Therapy will verify insurance eligibility and benefits. This is a courtesy and the information collected is only an estimate and does not secure payment by the insurance company. Dependent on insurance, Coastal Kids Therapy may collect a co-pay or co-insurance at the time of visit. I understand that Coastal Kids Therapy will bill Medicaid or Insurance Company either by electronic or manual method, for services rendered through our billing agency. This patient or legal guardian agrees to authorize direct payment of insurance benefits by insurance carrier to Coastal Kids Therapy. I understand that if my insurance carrier does not accept "assignment of benefits," I am obligated to endorse and send payments to Coastal Kids Therapy.

INITIALS _____

Client Financial Responsibility

With this consent, Coastal Kids Therapy may verify insurance coverage for therapy services. I understand that verification of benefits is not a guarantee of payment and I understand that if payment is not made to Coastal Kids Therapy by other payers, I will be responsible for the services rendered to my child. This payment will be made dependent upon a written notice. I understand that I am responsible for insurance deductibles and amounts not covered by any insurance or payment provider. We require co-payments, deductibles, and non-covered charges to be paid at the time of services. Please be aware that some, and perhaps all, of the services provided may not be covered under your particular benefit plan. Any verbal verification of benefits or coverage is never a guarantee of payment. If your insurance company has not paid services in full within 30 days, the balance will automatically be billed to your account. Balances in excess of 30 days must be paid before additional services can be rendered. We also have a returned check fee of $30 in addition to the amount of the original check. **THIS DOES NOT INCLUDE MEDICAID OR INNOVATION WAIVER RECIPIENTS. MEDICAID RECIPIENTS ARE REQUIRED TO MAINTAIN ACTIVE MEDICAID STATUS, BUT CAN NOT BE BALANCE BILLED FOR UNPAID CLAIMS**

INITIALS _____

Notification of Change

This patient or legal guardian agrees to notify Coastal Kids Therapy within 24 hours of any information change it receives regarding changes in Insurance, Medicaid, or other funds that affect the reimbursement.

INITIALS _____

This agreement will remain in effect for the duration of treatment, and you can revoke this agreement at any time in writing, except for services that have already been provided.

Communicable Diseases

Please cancel your child's appointment if one or more of the following conditions are present:

1. Temperature of 100 degrees or higher
2. Vomiting
3. Sore throat, persistent cough, or acute cold
4. Discharging eyes
5. Skin rashes
6. Suspected scabies or impetigo
7. Head lice
8. Diarrhea

Return to therapy guidelines:

1. Fever free for 24 hours
2. Symptom free of vomiting
3. Symptom free of sore throat, persistent cough, or acute cold
4. Treated head lice
5. Symptom free diarrhea

I agree to call and cancel my child's appointment in the event that he/she presents one or more of the conditions above. I agree to call and reschedule after illness has been treated and resolved.

_____

Print Child's Name Date of Birth Client/Parent/Legal Guardian Signature Date

Patient Information Release Consent Form

I understand that Coastal Kids Therapy may use or disclose my personal health information for the purpose of:

Carrying out treatment
Evaluating the quality of services provided
Any administrative operations related to treatment or payment
Appointment reminders
Information about alternative treatments
Consultation with other health care professionals

I understand that I have the right to restrict my personal health information when used for treatment, payment and administrative options. I also understand that Coastal Kids Therapy will consider restrictions of information on a case by case basis, but does not have to agree to restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted above. I understand that I retain the right to revoke this consent by notifying Coastal Kids Therapy in writing at any time.

I acknowledge that I have received the Coastal Kids Therapy HIPAA statement.

Patient name

_____

Your name and Signature

Date: _____

Release for Photography

Coastal Kids Therapy may film a video or take pictures for the purpose of explaining OT, our programs and our philosophy. These images may be used on our web site and Facebook page.

We will ensure that any photography will not disrupt your child's therapy session.

If you prefer that any footage be edited so that your child is not visible, please sign here:

_____ Date: _____

If you grant permission to include footage that may include your child, please sign here:

Child's name:

_____

Your name & signature: _____Date: _____

Allergy Information Update Form

Today's Date: _____

Child's Full Name: _____ Date of Birth: _____

Does your child have any allergies: _____ Yes _____ No

If yes, please explain:

_____

_____

_____

Does your child require an Epi Pen? _____

If yes, do they have the Epi Pen with them? _____

Does your child follow any special diet, have feeding issues or avoid certain foods?

_____

_____

_____

Emergency Contact Name and Phone Number:

_____