THERACARE
PEDIATRIC SERVICES

Welcome to Theracare Pediatric Services

Please fill out all of the enclosed forms. We ask that you fill them out completely, sign and date where asked. If the forms are not filled out completely, this may result in termination of services and you will be responsible for payment of services rendered. **Please note, in addition to you signing and dating the form, Theracare Pediatric Services needs your current insurance information.**

Theracare Pediatric Services needs to have all forms completed and returned by email or standard mail prior to your therapist beginning services.

Our therapists always do their best to stay on schedule, but sometimes there are unforeseen circumstances (i.e. traffic accident, etc.) that arise and alter the arrival time. We ask that you please practice patience during these circumstances and work with the therapist to coordinate rescheduling your appointment if the therapist cannot make it to your appointment in a timeframe that works for you. All times are approximate and if our therapist is running fifteen (15) or more minutes late, they will contact you directly.

If you need to reschedule or cancel an appointment, please give a 24-hour notice and contact the therapist directly to inform them of your intent to cancel.

We encourage feedback as it relates to services rendered by Theracre Pediatric Services by either informing your therapist or reaching out directly to: (602) 875-5610. You may also fax us at 602-324-0818, or set an appointment at the office. Theracare's office is located at:
21620 N. 19th Ave., Suite A6, Phoenix, AZ 85027. You may also email the Director of Operations Paige Peterman, at ppeterman@theracareaz.com to communicate any questions and/or concerns you may have.

On occasion, the insurance companies may send a check payable to you for therapy services rendered by Theracare. If this happens, we ask that you please sign the check, and then write "Pay to the order of Theracare Pediatric Services" where appropriate, then mail the check, along with the Explanation of Benefits (EOB) to: 9385 W Donald Dr. Peoria, AZ 85382. ***Please note: If you receive a payment from your insurance company, you have 5 days to submit this payment and EOB to Theracare. If both, or either the payment and EOB are not recieved within this timeframe, you will be billed the full amount for therapy services rendered.**

Theracare Pediatric Services is required to verify your insurance from time-to-time. This will always be done in January of each year, and possibly throughout the subsequent calendar year. **If your insurance changes at any time, for any reason, it is your responsibility to contact Theracare Pediatric Services and/or your therapist immediately in order to update us with your new insurance information.** Failure to submit a request for updating new insurance information with Theracare and/or your therapist within ten (10) days of this change will result in you being financially responsible for all services rendered until new information is submitted.

PLEASE RETAIN AND KEEP HANDY THE INFORMATION ABOVE FOR YOUR RECORDS

INSURANCE INFORMATION

CLIENT NAME: _____

CLIENT ADDRESS: _____
(address) (city) (state) (zip)

PHONE NUMBER: (____)_____-_____ SEX: _____ DOB: _____/_____/_____

PARENT/GUARDIAN NAME(S): _____

CLIENT'S PRIMARY CARE PROVIDER(PCP) (FULL NAME): _____

PCP ADDRESS: _____
(address) (city) (state) (zip)

PCP PHONE NUMBER: (____)_____-_____ DIAGNOSIS: _____

INSURED INFORMATION (Parent/Caregiver info if client is listed under insurance)

NAME OF POLICY HOLDER: _____

ADDRESS: _____
(address) (city) (state) (zip)

PHONE NUMBER: (____)_____-_____ SEX: _____ DOB: _____/_____/_____

EMPLOYER: _____ EMPLOYER PHONE: (____)_____-_____

INSURANCE COMPANY INFORMATION

INSURANCE CARRIER: _____

EFFECTIVE DATE: _____/_____/_____ PLAN ID NUMBER:_____

BILLING ADDRESS: _____
(address) (city) (state) (zip)

PHONE NUMBER: (____)_____-_____ PAYOR ID#: _____GROUP#: _____

***Please alert Theracare PLLC if there is a secondary insurance policy.**

AUTHORIZED SIGNATURE

I hereby authorize the release of any medical or other information necessary to file a claim with my insruance company. I also request payment of government and/or insurance benefits to Theracare Pediatric Services. I understand that I am responsible for any and all bills incurred and that any third party coverage or insurance is for the purpose of assisting me with my responsibility. If I receive a payment from the insurance company, I understand that this payment along with the Explanation of Benefits (EOB) needs to be submitted to Theracare Pediatric Services within five (5) business days of receipt of this information or I will be billed directly for all services rendered. I also have received the "Welcome to Theracare Pediatric Services" form and understand that I am responsible for notifying Theracare Pediatric Services and/or the therapist providing services of a change in insurance coverage, and that I need to fill out a new INSURANCE INFORMATION form within ten (10) days of my insurance changing. I will be responsible for all services rendered if I do not submit updated insurance information within the allotted ten (10) day period of such changes occuring.

_____ _____
Responsibility Party Printed Name Date

_____
Responsibility Party Signature

MEDICAL RELEASE

I, _____, hereby certify that I am a parent or legal guardian of _____, and give Theracare Pediatric Services permission to provide services to _____.

I authorize Theracare Pediatric Services to request, obtain, and provide medical information to and from the appropriate doctors, medical facilities, insurance companies, payment services, and/or any other entity that will assist in rendering therapy services.

_____ _____

Responsibility Party Printed Name Date

_____

Responsibility Party Signature

CANCELLATION POLICY

If I need to reschedule or cancel an appointment, I will attempt to give a 24-hour notice and contact the therapist directly to inform them of such while offering a makeup session if one is available. I understand that if I call our office to cancel an appointment, Theracare Pediatric Services will try their hardest to get in contact with the therapist. Theracare Pediatric Services cannot guarantee that the therapist will get the message in a timely manner. Please note services may be put on hold or cancelled by the agency when three (3) consecutive no show appointments or cancellations, or a combination of each, occur. I understand it is important to maintain consistency in my child's therapy to ensure improvements are made and multiple missed appointment does not cater to that. Theracare Pediatric Services reserves the right to discontinue services at any time.

I also understand that the therapist will call if they are going to be more than 15 minutes late for a scheduled appointment. It is my responsibility to ensure that Theracare Pediatric Services and the therapist have my most up-to-date information to include telephone number and address. I also understand that the therapist will keep all appointments and from time to time may need to cancel/reschedule an appointment within less than 24 hours due to illness/emergency. If I feel that the therapist cancels frequently or is not providing quality services, I will contact Theracare Pediatric Services immediately to resolve these issues.

_____ _____

Signature of Parent/Legal Guardian Date

NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the mulitiple healthcare and providers, and school officials(if applicable) who may be involved in that treatment directly and indirectly.

2. Obtain payment from a third party payer (insurance policy).

3. Conduct normal healthcare operations such as quality assessments.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of the patient's healthcare information. I understand that this organization has the right to change its Notice of Privacy Practices from time-to-time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how the patient's private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree in writing, then you are bound to abide by such restrictions.

In an effort to reduce Theracare Pediatric Services carbon footprint, I give my permission for Theracare Pediatric Services and its therapists to email me all therapy reports to include evaluations, and ongoing reports. I understand that although all email services encrypt data that is sent via email, Theracare Pediatric Services does not make any warrrantee of guarantee the security of the data and cannot be held responsible for any breach of security.

The email address I wish to have all therapy information sent to is:

EMAIL: _____

CLIENT NAME: _____ DOB: _____/_____/_____

GUARDIAN/RESPONSIBLE PARTY NAME: _____ RELATIONSHIP: _____

_____ _____
Responsibility Party Printed Name Date

_____
Responsibility Party Signature

OFFICE USE ONLY

I, _____, attempted to obtain the responsible party's signature in acknowledgement on this Notice of Privacy Practices information, but was unable to do so as documented below.

DATE: _____/_____/_____

REASON: _____

_____ _____
Therapist or Office/Billing Manager Signature Date

NOTICE OF MEDICAL PRIVACY PRACTICES

This notice describes how medical information may be used and disclosed, and how you can get access to this information. Please review carefully.

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical information used or disclosed by us in any form, whether electronically or on paper, or orally, are kept properly confidential. This act gives you, the patient or patient's representative significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse 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.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

1. Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.

2. Payment means such activities such as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.

3. Health care operations includes the business aspect of running our practice, such as quality assessment and improvement activities, auditing, cost management analysis, and customer service.

We may also create and distribute de-identified health information by removing all reference to individuality identifiable information.

We may contact you to provide appointment reminders of information about treatment alternatives or other health related benefits and services that may interest you.

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 actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the provider.

1. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a written requested restriction. If we agree to a restriction, we must abide by it unless you agree in writing to remove it.

2. The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.

3. The right to inspect and copy your health information.

4. The right to amend your protected health information.

5. The right to receive an accounting of disclosures of protected health information.

6. The right to obtain a paper copy of this notice from us upon request.

PLEASE RETAIN THIS PAGE FOR YOUR RECORDS

PRIVATE PAY RATES (effective January 2019)

Evaluation: A one-time fee for your child to be evaluated by a therapist of a certain discipline (ie: Speech) to determine if ongoing services are recommended.

Session: The evaluation report may indicate your child could benefit from therapy sessions (generally one time per week, depending on the evaluation outcome). This charge will be incurred for each session rendered. The typical therapy session lasts 60 minutes.

Base vs. Tier: Fees for service vary based on your physical location. This is only applicable if in-home services are chosen.

	CLINIC SERVICES	IN-HOME SERVICES	
Speech, Occupational, and Physical Therapies	Evaluation: $175* OT/ Speech Session: $60* Physical Therapy Session: $80*	Base Rate:	Evaluation: $250* Session: $80*
		Tier 1:	Evaluation: $275* Session: $90*
		Tier 2:	Evaluation: $300* Session: $100*
		Tier 3:	Evaluation: $350* Session: $110*

*In-network insurance plans may differ. Theracare Pediatric Services will accept the allowable amount by an in-network insurance company as full payment. The client will still be responsible for any deductible/copay/coinsurance indicated on the EOB (Explanation of Benefits) by the insurance policy. The client will be notified if Theracare Pediatric Services is in-network with their insurance policy prior to beginning services.

- You will be responsible for the above costs after services have been rendered. If an insurance policy(ies) exist, Theracare Pediatric Services will bill the policy(ies) before billing the client. Any costs not covered by the insurance policy(ies) up to the amount indicated above will become the responsibility of the client. (see above comment for in-network insurance policies)

- Clients will be billed once per month and will have 30 days from the date of the invoice to pay any outstanding balances. **Any balances not paid within 30 days of the invoice date will result in a suspension of services until the balance due is paid in full.**

- NO CALL/NO SHOW: Please alert your therapist within 24 hours of the scheduled appointment if you are unable to keep your session. If you do not call your therapist to cancel the appointment within 24 hours of the scheduled session, Theracare Pediatric Services reserves the right to bill you $35.00 for the missed session. This will not be billed to insurance and is the client's responsibility entirely.

By signing below, you agree to the aforementioned terms of service.

Signature of parent/guardian: _____ Date: _____

Theracare Pediatric Services Payment Options

** Theracare Pediatric Services maintains a strict on-time payment policy. Please choose from the following payment options:

- **Automatic credit card option**
  For your convenience, we will automatically bill all services rendered to your Visa or MasterCard on file. Please note that insurance companies may process claims quickly or may need more information from Theracare Pediatric Services (ie: session notes, prescription, etc) resulting in a slower processing of the claim. Because of this you may notice varying amounts charged to your card from month to month. Theracare Pediatric Services will email you receipt of payment indicating the dates of service you were charged for.

- **Receive monthly invoices via QuickBooks® to your email on file**
  If you select this payment option, payment must be remitted to Theracare Pediatric Services within 30 days of the invoice date. If payment is not received by Theracare Pediatric Services in a timely manner, services will be suspended, and we reserve the right to send your outstanding balance to a collections agency.

Card Type	Card Number	Expiration Date	CVV Code*
Visa			
MasterCard			

*CVV code located on the back of card (3 digits)

Name as it appears on card: _____
Billing address associated with card: _____
City: _____ State: _____ Zip Code: _____

Signature of Responsible Party: _____ Date: _____

Name of Client: _____

*if at any time you choose to change your payment option, please email michelle@theracareaz.com or call 602-775-5145.

PREFERRED MODE OF CONTACT

*Please check the bubble next to your choice below. Please indicate preferred phone number(s) or E-Mail address(es) next to chosen mode of contact. If we are unable to reach you by your indicated preferred mode of contact, we will follow up another way.

- TEXT: _____-_____-_____
  - I give permission to use client information in the text message (ie: Name)
  - I do not give permission to use client information in the text message

- PHONE CALL: _____-_____-_____
  - I give permission to leave a voicemail with client information (ie: Name)
  - I do not give permission to leave a voicemail with client information

- E-MAIL: _____
  - I give permission to use client information in the email (ie: Name)
  - I do not give permission to use client information in the email

Signature of Responsible Party: _____ Date: _____

Printed Name of Responsible Party: _____