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.**

If you have private insurance, please include it where asked below and keep the Explanation of Benefits (EOB) when you receive these in the mail as they are documents that will assist in billing for services rendered. If you do not have private insurance, please provide your AHCCCS information where appropriate. The Division of Developmental Disabilities (DDD) requires us to bill all private insurance before we can bill AHCCCS/DDD for services rendered.

Theracare Pediatric Services needs to have all of these forms completed and given to your therapist no later than seven days from the initial visit of therapy.

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 fiffteen (15) or more minutes late, they will contact you directly.

If you need to reschedule or cancel an appointment, please attempt to give a 24-hour notice and contact the therapist directly to inform them of such. If you call our office to cancel an appointment, we will try our hardest to get in contact with the therapist, but cannot guarantee that your therapist will get the message in a timely manner.

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 Pediatric Services 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. **_____Initials**

PLEASE RETAIN AND KEEP HANDY THE INFORMATION ABOVE FOR YOUR RECORDS

CLIENT INFORMATION

CLIENT NAME: _____

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

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

DDD SUPPORT COORDINATOR NAME: _____ PHONE NUMBER: (____)_____-_____

PARENT/GUARDIAN NAME(S): _____

CLIENT DOCTOR (FULL NAME): _____

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

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

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

IMPORTANT: If the client is covered under private insurance(ie: Aetna, BCBS, Cigna, etc., not AHCCCS policies), you MUST disclose that information here. DDD(Department of Developmental Disabilities) is the payor of last resort, and Arizona Autism is required to bill any active private policies prior to billing DDD. If DDD has private insurance on file for the patient, and you do not disclose it to Arizona Autism, we will obtain the insurance information from DDD and bill your private policy first. **Initials_____

NAME: _____

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

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

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

INSURANCE COMPANY INFORMATION

INSURANCE CARRIER: _____

EFFECTIVE DATE: _____/_____/_____ PLAN: HMO / PPO / OTHER:_____

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

PHONE NUMBER: (____)_____-_____ ID#: _____ GROUP#: _____

*If the client is covered by a secondary **commercial** plan, please alert Theracare Pediatric Services

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 withing five (5) business days of receipt of this information of 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, 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 accuring.

_____ _____
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 cancel an appointment, I understand that I will cancel/reschedule an appointment by giving a 24-hour notice when possible. 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

PRE-SERVICE PROVIDER ORIENTATION

INSTRUCTIONS: This form is to be completed by the provider and the individual and/or responsible party receiving services prior to the initiation of said services. A copy **MUST** be retained by the provider. The provider **MUST** also ensure that the **MEDICAL RELEASE** form, **INSURANCE INFORMATION** form, and the **HIPAA** form are completed and retained by the provider.

PROVIDER NAME: Theracare Pediatric Services

SPECIAL TRAINING: All Speech Therapists are State Licensed and at a minimum have their Masters. All Occupational Therapists are State Licensed and at minimum have their bachelors if they graduated before 2007, or their Masters after 2007. All Occupational Therapy Assistants have an Associates Degree and are supervised by an Occupational Therapists. All Speech Therapy Assistants have an Associates Degree and are supervised by a Speech Therapist. All Physical Therapists are State Licensed.

MED TRAINING: Under NO circumstances will our therapists give medications to clients.

TRANSPORTATION: Under NO circumstances will our therapists transport a client and/or their family member(s).

TREATMENT: There MUST be an adult or legal guardian (over the age of 18) present during all provided therapy sessions, and at no circumstance shall services be rendered behind closed doors.

CLIENT NAME: _____ DOB: _____/_____/_____

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

PHONE NUMBER: (____)_____-_____ EMAIL: _____

GUARDIAN/RESPONSIBLE PARTY NAME: _____ RELATIONSHIP: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

EMERGENCY CONTACT PHONE: (____)_____-_____

DDD SUPPORT COORDINATOR NAME: _____ PHONE NUMBER: (____)_____-_____

PRIMARY CARE PHSYICIAN NAME: _____ PHONE NUMBER: (____)_____-_____

HEALTH & MEDICAL INFORMATION

Theracare Pediatric Services and its contracted therapists do not and will not administer medications. If there is a medication log for the client, you may inform our therapist of such a log for information purposes only.

CURRENT MEDICATION(S): _____

FREQUENCY OF MEDICATION(S): _____ EFFECT(S): _____

KNOWN ALLERGIES: _____

RECOMMENDED RESPONSE TO ALLERGIES: _____

SEIZURE ACTIVITY: YES / NO IF YES, FREQUENCY: _____ DURATION: _____

ASSISTIVE/PROTECTIVE DEVICES/SPECIAL INSTRUCTIONS: _____

_____ _____
Therapist Signature Date

_____ _____
Responsible Party Signature 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, school officials, and representatives for the Division of Developmental Disabilities (DDD) who may be involved in that treatment directly and indirectly.

2. Obtain payment from a third party payer.

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 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