

To avoid owing money you do not expect, it is your responsibility to call your insurance company to verify your benefits.  
Here are some questions to help you when making your call:

Is ABC Pediatric Therapy Network in-network? (If your insurance is Aetna, we are in-network)

Deductible: Family: \_\_\_\_\_ Individual: \_\_\_\_\_

Co-Pay: \_\_\_\_\_ Co-Ins.: \_\_\_\_\_

Number of visits:

OT: \_\_\_\_\_ PT: \_\_\_\_\_ SP: \_\_\_\_\_

Are there any exclusions to the number of visits quoted above?

Is authorization needed?

Can we get additional visits approved once above visits are exhausted?

If you have any questions after receiving this information from your insurance company, please feel free to contact our billing department at 755-6600.

**Name:**

2012 Patient Information Form

Date: \_\_\_\_\_  
Child's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F

Child's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Guardian Name (1): \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Guardian Name (2): \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Referring Physician/Pediatrician (Name and Facility): \_\_\_\_\_

Physician phone number: \_\_\_\_\_ Physician Fax Number: \_\_\_\_\_

Primary Insurance:

Policy Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

SSN: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance (if applicable):

Policy Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

SSN: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Assignment of Payment

Authorized person's signature: I hereby assign the medical benefits to which I am entitled from private insurance and other health plans to ABC Pediatric Therapy Network. A photocopy of this assignment is to be considered as valid as an original. I authorize ABC Pediatric Therapy Network to release information necessary to secure payment. I understand that I am financially responsible for all charge whether or not paid by insurance. I authorize ABC Pediatric Therapy Network to receive direct payment for therapy services rendered to my child.

Signed \_\_\_\_\_ Date \_\_\_\_\_

B/T

# ABC Pediatric Therapy Network



**Specializing in pediatric OT, PT, and Speech Therapies**

9902 Windisch Rd. • West Chester, Ohio • 45069

Phone (513) 755-6600 • FAX (513) 755-3762

## Release of Information Form

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Guardian/s \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_

Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_ Date \_\_\_\_\_

- I hereby authorize any physician, clinic, hospital, institution or school to release medical and psychological information regarding my child, (Child's Name) \_\_\_\_\_ to ABC Pediatric Therapy Network. I understand that this information is to be used for professional purposes only and that it will be regarded as confidential. I also authorize ABC Pediatric Therapy Network to contact any persons or institutions to obtain any additional information regarding my child, when necessary.

Signed \_\_\_\_\_  
(Guardian)

- I hereby authorize ABC Pediatric Therapy Network to release therapy reports regarding my child, (Child's Name) \_\_\_\_\_, to any entity or professional associated with my child's care (physicians, any clinic, hospital, institution, insurance company, school, and other), with the exception of \_\_\_\_\_. This authorization includes release of information concerning HIV testing or treatment of AIDS, AIDS-related conditions, drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions.

Signed \_\_\_\_\_  
(Guardian)

This consent will expire in 1 year or after all billing issues related to this treatment will have been resolved. This consent may be revoked at any time through a written request to ABC Pediatric Therapy Network.

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## ABC Pediatric Therapy Network

### REIMBURSEMENT POLICY

As has always been our policy, the family is responsible to call their insurance company and be aware of their benefits. They are responsible to pay out of pocket fees at the time of service. Families need to keep track of the number of visits or when precertification is necessary. The number of visits and the payment of all claims is the responsibility of the family and not ABC Pediatric Therapy Network.

ABC Pediatric Therapy Network, as a benefit to our clients, will submit claims to your insurance. This again is not our responsibility, but it is being provided as a benefit to you.

Family should call at least monthly to be sure claims are received and being processed.

Unpaid claims are called on by ABC at least every 30 days. After 60 days, ABC will inform the parents of unpaid claims.

After 90 days without payment, the family will be responsible to begin paying on their account balance and private pay future appointments in order to remain on the treatment schedule.

If a claim has been denied and is going to through the appeals process, the family must begin paying on the balance and private paying any new treatment sessions.

Much of this can be avoided by knowing your policy and following up on your claims. The bills are ultimately your responsibility. ABC is only required, once treatment is provided, to give you the information to get reimbursed from your insurance company. Submitting the claims is not our responsibility but a benefit to you.

Please help us to keep our costs down and to continue to provide the best quality care possible.

Thank you for your help in this matter.

ABC Pediatric Therapy Network

Signature of Guardian: \_\_\_\_\_

# ABC Pediatric Therapy Network

## NOTICE OF PRIVACY PRACTICES

\*\*This Notices describes how health information about your child may be used and disclosed and how you can get access to this information.

The federal government has legislated the Health Information Portability and Privacy Act (HIPPA). The new rules regulate the privacy and accessibility of health information regarding your child's care at ABC Pediatric Therapy Network. We must follow these privacy practices that are described in this notice until it is changed. It takes effect 4/14/03. You may request a copy of your notice at any time as applicable by law. Any changes will be added to this form will be available to you. You may request a copy of this at any time.

### Use and Disclosure Information

**Treatment**-We may use or disclose your child's health information to plan a course of treatment that includes evaluation, goals and treatment approach. At times, your child's medical information may be reviewed by a student intern at our facility. In addition, your child's medical records will be provided to your health plan and referring physician. Your child may receive therapy services in the same room with another child. When in the treatment area, your child's goals and data pertinent to your child's treatment may be discussed with other professionals and family members.

**Payment**-We may use and disclose your health information to obtain payment for services we provide to you/your family member. A bill may be sent to you or your health insurance payer. The information on the bill may obtain information that identifies you, your spouse or your child. This information may include the child's date of birth, diagnosis and procedures or supplies used.

**Appointments**-We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

**Check-In**-Your child's name may be called when checking in at our window. Your child's name will be written on a sign in sheet.

**Schools and Agencies**-We may provide information requested for IEP's, MFE's and evaluations with other professionals. We may disclose your child's information to doctors and other health professionals in regards to your child's care with us.

### Other Permitted Uses and Disclosures

To public health authorities charged with preventing or controlling disease, injury or disability. We will notify appropriate persons if we suspect child abuse or neglect.

We may need to provide medical information regarding your child to legal/judicial/administrative and law enforcement person. We may need to send you information regarding your child's care or billing issues through the mail. We may also send you information about groups and programs. This information may come in a marked envelope with our address on it. We will not use or disclose your child's health information without your written authorization.

### Patient's Rights

- You have the right to view your child's health record and request a copy of it. There may be a copying and postage fee. You may be asked to show proof of guardianship or parent (driver's license, court order)
- You may request an amendment to your child's record. We are not required to make this change, but it will be noted in the record.
- You may restrict anything in our privacy act by completing a restriction request form. We are not required to honor your request, but will make all efforts to accommodate reasonable requests. You may fax or mail this to us.
- Provide written authorization for uses and disclosures not otherwise permitted by law.

**If you believe your privacy rights have been violated, you can file a complaint with our privacy officer or with the Secretary of Health and Human Services.**

Secretary-US Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

### Signature:

I have read and understand/agree with ABC Pediatric Therapy Network's Privacy and Policy Act.

\_\_\_\_\_ Date: \_\_\_\_\_

I have been give a copy of this for my records

\_\_\_\_\_ Date: \_\_\_\_\_

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# ABC Pediatric Therapy Network

## ATTENDANCE POLICY

### **Scheduled Appointments:**

- Please arrive for each appointment in time to check in and begin therapy at the scheduled time.
- A late fee of \$15 may be assessed if you are 10 or more minutes late for your appointment. If there is a difficulty getting to your appointment, please discuss this with the front desk so we can recommend another appointment time.
- If you leave during your child's therapy session, we request for you to return 15 minutes prior to the session being complete to enable the therapist to discuss your child's progress.

### **Cancellations:**

- If you must cancel an appointment due to an illness or emergency, contact our front office **24 hours** before the scheduled appointment or a \$25 fee may be assessed. Our office staff will then ask for your availability to reschedule the appointment.
- Please verify with the front desk any appointments that will be canceled due to a vacation. We request to receive this information at least 14 days prior to the date which will be missed. Currently, we are unable to hold any time slot more than 2 consecutive weeks due to a vacation.
- In the event of inclement weather, contact our office the day of the event if you are unable to make it to the appointment. A fee will not be assessed.
- Frequently canceled appointments (more than 1 canceled visit for every 8 visits scheduled) will be basis for removal from our permanent schedule and allow you to only schedule on a week to week basis.

### **No Shows:**

- Failure to cancel or to appear during an appointment is considered as a no show. A \$25 fee will be assessed. Please contact our office immediately to discuss future appointments.
- If two no shows occur, your child's appointment time will be automatically offered to another child waiting for services.

### **A Note from the Therapists:**

We expect for you to make every effort possible to attend your scheduled appointments. When we establish a plan of care for your child, we base our goals on the child having consistency. If your child misses appointments, they will not meet their goals as quickly, and your child will have to be enrolled in therapy for a longer period of time. The success of our treatment sessions depends on consistency. In the event that you do have to cancel, we strongly encourage you to reschedule, even if it is with another therapist. We actually enjoy when another therapist sees one of our patients because it gives us another opinion of ideas for your child. We are always in close communication with each other. Any other concerns you may have regarding your child, please discuss this with your therapist.

I have read the attendance policy and understand the attendance expectations for my child.

---

Parent/Guardian Signature

Date

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**ABC Pediatric Therapy Network**

**EMERGENCY MEDICAL FORM**

Child's Name \_\_\_\_\_

Allergies \_\_\_\_\_

Medical Precautions \_\_\_\_\_

\_\_\_\_\_

Contact person in case of emergency \_\_\_\_\_

Phone Number \_\_\_\_\_

2<sup>nd</sup> Contact  
person \_\_\_\_\_

Phone Number \_\_\_\_\_

Our Policy is to call 911 in the case of any medical emergency. Please indicate if you would like us to do otherwise:

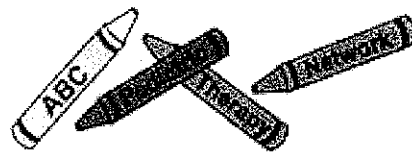
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent/Legal Guardian Printed  
Name \_\_\_\_\_

Parent/Legal Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

T



**ABC Pediatric Therapy Network**  
*"creating the best life for all children"*

**West Chester**  
 Phone: 513-755-6600  
 Fax: 513-755-3762

**Western Hills**  
 Phone: 513-922-5437  
 Fax: 513-922-1530

**Middletown**  
 Phone: 513-755-6600  
 Fax: 513-755-3762

**Centerville**  
 Phone: 937-281-1286  
 Fax: 937-281-1298

**ATTENDANCE – ANSWERS TO COMMON QUESTIONS/EXPECTATIONS**

Why do you have a policy?	We know based on research and data that kids make the best and most significant progress when seen frequently and consistently. Our goal is to partner with you and your child in meeting the goals that have been set as quickly as possible.
Why is it so important that we arrive on time?	Your therapist has scheduled time and activities specific to your child and wants to be able to address each goal thoroughly every session that your child attends. Also each therapist sees a number of patients daily with many appointments being scheduled one after another. So when a child arrives late the time cannot be made up or would interrupt the next child's individual session.
Why do you ask us to reschedule our appointments when we cancel?	We want to provide the best outcomes possible for each child seen at ABC. This requires consistent attendance and timely arrival at least weekly. Any cancellations interrupt the progress of therapy and can make the time in therapy longer and reduce the quality we are providing.
What if my therapist is not available to reschedule with?	We have staffed ABC to allow rescheduling to occur. Our friendly front desk staff will do everything they can to find a time that works. Our therapists are hand selected and have all completed strict competencies in their area of expertise.
What if I do cancel more than 2X in an 8 week period?	By the 2 <sup>nd</sup> cancel the policy should have been reviewed with you by your therapist and/or front desk person at least 2X since you began your initial treatment at ABC. The cancel history information we gather encourages ABC to offer other options for getting your child's needs met. Our primary goal is to meet your child's needs and successfully discharge them from therapy as quickly as possible.
What options do I have once I have been removed from my weekly time?	Once it has been determined that setting weekly reoccurring appointments is not providing your child a chance at success with his or her goals you will be offered an "on call" status.
What does "on call mean?	It can often be hard for some families to schedule and keep weekly reoccurring appointments. We realize that families have a lot going on. "On call" provides families the flexibility they may need. It allows the family to tell ABC what time works for them each week. This may change as often as the family needs it to and is scheduled by the parent one week prior to the next appointment. These appointments can be made by phone or at the check -out desk following each appointment.
Will I see the same therapist each time I receive therapy?	In order to provide the most flexibility to you and your family scheduling with the therapist available that matches your time request is preferred. Even with a policy in place all therapists do get cancels. So sometimes you may get lucky and be able to coordinate with a particular one but this does not meet ABC's goal of getting your child in consistently. We want your child to meet his or her goals.
If I decide I want reoccurring appointments back how do I do that?	If you find a time that works for you, attend it consistently with timely arrival for at least 4 weeks, and it becomes available on a therapist schedule you can discuss being placed back into a weekly reoccurring appointment.
Things come up and this still does not seem fair and I feel sometimes like I am being punished.	ABC's goal is to create the best life for as many children as we can. We know that it requires commitment and dedication from the family to do this. We also understand that families have things come up and commitments that they need to attend. Our staff does everything they can to provide flexible options for families. However, ABC is a business and each staff member only has so much available time to give. It is important that the time ABC gives is spent providing successes for families. This requires consistent weekly attendance. ABC wants to make sure that each and every time slot available is full each week so that we can impact as many children as possible. When a family cancels an appointment this can be a missed opportunity for another family who may be waiting for an available time to have their child's goals met.

**-PLEASE KEEP THIS PAGE FOR YOUR RECORDS-**