New Patient Information Packet

Headquarters - 128 Fayette St. - Martinsville, VA 24112

Important information we need about your child

General Information:

Child's Name: ____ Date of Birth: __________________
Address: ____ Phone: _______________________
City, State, Zip: ____

Insurance Company:_______________________________ Member ID:_______________________________

Relation To Patient:_________________________ Responsibility:____________________________________

Who does the child live with? ____

Parent/Legal Guardian's name: ____

Please list the individuals authorized to consent to medical treatment (ex: grandparents, aunt, etc.)

Name: _____________________________________Relationship to child:_________________________

Name: _____________________________________Relationship to child:_________________________

Name: _____________________________________Relationship to child:_________________________

Name: _____________________________________Relationship to child:_________________________

Medication List:

This includes prescriptions, over the counter, and nutritional supplements. Separate List provided? ___Yes ___No

Medication/Drug Name	Dosage	Times/Day

Fees and Policies

initials	Our fees and policies are applied consistently for all clients. Our staff do not make our policies or set our fees and they are unable to waive or change them. Please do not ask them to make exceptions for your family. Our office staff will discuss your concerns with you if you request. We regret any inconvenience. Our fees are subject to change without notice. Any client may leave services any time, given notice, if they do not wish to comply with our policies.
Holiday Closures	

initials	Our office will be closed for the observation of the following holidays: New Years Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day, and Christmas Day. Please do not assume we are closed on days you may have off from work or school. We are open during many of the typical school holidays. If you are unsure if we will be open or closed on a specific holiday kindly call us to inquire.
Therapy Sessions	

initials	Therapy sessions are 30-60 min for all pediatric clients. We must conclude promptly at the end of our scheduled session to maintain the timeliness of our appointments. If you have extra questions on any day, please let the therapist know at the start of the session so enough time for answers can be saved until the end of the session. If you do not notify us that you are requesting additional time for questions we will have to address your questions at our next scheduled session. Kindly do not ask our staff to extend your session. An adult must remain on site for the duration of a child's session in case of emergency, toileting issues, etc. Our staff will not—at any time—assist a child to the bathroom alone. Let our staff know if you will need to leave the office to go outside so we can easily find you if any issues arise. Please do not leave to run errands. If the person bringing a child to therapy is not the parent (babysitter, grandparent, etc.). we will update them regarding the child only if we have a release of information signed for that person. You may list them in the above section of this information packet.

Scheduling

initials	We may have a waiting list for our "high demand" therapy times. Preference is given to our current clients who desire to change or add an appointment time. We cannot guarantee when an appointment time may become available. Our business office staff can assist you with your scheduling requests. Our greatest demand is for after-school and before-work appointments however, there are a limited number of appointments during that time. Sessions during these times may be filled and you may have to wait for clients to exit therapy before we can offer an appointment during that time. We cannot guarantee how long it will take to have an appointment available for you. We ask that you not become upset with us if we are not able to accommodate you as quickly as you would like.

Termination of Therapy

initials	The following may be reasons to terminate our relationship with a client. • Behavior of a parent • Non-compliance with our Attendance/Cancellation Policy • Repeatedly not paying an account • Engaging in unethical behavior such as withholding information about the case history or asking us to alter our data or diagnosis

Waiting Room and Treatment Room Etiquette

initials	If your child soils their diaper or pull-up, we will ask that you change it quickly. We are unable to open windows/doors in our office/waiting room for ventilation. Odors make for an unpleasant environment for our clients and staff. If you do not have a change of diaper or pull-up we will ask that you clean them up as best you can in the restroom. If the odor persists, we may need to terminate the session. Food or drink is not allowed in the waiting room. If you need to eat or drink please do so before the session or in your vehicle. We have patients and staff with significant allergies and allergy-triggered asthma. If you wear a strong perfume or cologne, you may be asked to not sit in the therapy room. We do not allow behaviors in our waiting room or facility that may injure your child or others nor do we allow behaviors that might disturb the work of our staff. Please make every effort to redirect noncompliant behaviors of both the patient and any accompanying children while in the waiting room. If you feel you need assistance with your child's behavior, please let our office staff know and they will provide assistance or see if your child's therapist is available. Our staff may provide gentle reminders from time to time. Adults may not yell at, curse at, threaten, belittle or speak abusively to our staff or therapists if they are displeased with our policies, fees, their child's progress, scheduling. insurance denials. etc. in our facility or on the telephone. This creates an unpleasant and uncomfortable situation for all involved. It frightens and upsets our staff and clients. If you do this in the office, you will be asked to leave the premises. If you do this by telephone, our staff has been instructed to terminate the call. You may call back when you can speak calmly with us.

Special Meetings

initials	If you request a special meeting for any reason (i.e. to discuss progress, treatment planning) there is a charge for that session at our usual rate. We are unable to bill insurance for a meeting. If you schedule a special meeting, it will be held outside of your child's treatment time. You may not use your child's scheduled therapy session to hold a meeting. The week of the meeting your child will need to attend his or her regularly scheduled appointment in addition to you attending the meeting. If you schedule a meeting and do not attend you will be billed for that meeting as the therapist has prepared for this appointment and has scheduled time to see you. We do not develop IEP goals for families, however we may be able to attend IEP meetings should our schedules allow and our normal hourly rate would apply. We will speak with your child's school-based therapist on the phone if needed. There is no charge for calls of 10 minutes or less. A fee will incur for calls over 10 minutes in length. If you ask us to write in a communication book with a school-based therapist, we will do so during your child's appointment. If our therapists are subpoenaed in lawsuits that families file against doctors, medical facilities, or if your lawsuit requires us to attend a deposition or trial appearance you will be billed for the following: • Our hourly rate for time spent preparing for the deposition or court appearance • Our hourly rate for travel to and from the site and our waiting time • Our hourly rate for the time spent talking with lawyers, going to court. etc. • Our legal costs. if applicable.

Consent for Treatment

initials	I consent to and authorize ACME Therapies, Co. to render any and all applicable therapy services to my child that the therapist deems necessary or advisable to me in conjunction with my child's physician referral.

Certification of Information

By signing below, I certify that the information that I have provided to ACME Therapies, Co. for payment or treatment including but not limited to: contact information, insurances, related accidents, or illnesses is accurate and truthful. I will immediately advise ACME Therapies of any change in insurance coverage/claim status.

Parent/Guardians signature: ____Today's Date:_______________

Notice of Privacy Practices / Release of Information Form

By signing below, I certify that I have been offered a copy of the Notice of Privacy Practices for ACME Therapies. I recognize that outside of purposes for treatment, payment, certain healthcare operations or as permitted or required by law, I must give my written authorization to ACME Therapies to release any of my protected healthcare information.

With whom may we release medical records or other related information?

We will always request a photo ID before releasing any written information to anyone in person.

Name: ____

Name: ____

Name: ____

Name: ____

What may we release to those listed above? (ONLY INITIAL ONE OPTION)

initials	NONE of my records, EXCEPT with my child's insurance company, doctor, or myself.
Initials	ALL of the records regarding my child's care at ACME Therapies
Initials	Medical Records
Initials	Scheduling / Attendance Information
Initials	Billing, payments, and insurance claims processing information

How long is this Authorization Valid? <u>(ONLY INITIAL ONE OPTION)</u>

Initials	until I request to change this or revoke this authorization
Initials	From _____ / _____ / _________ to _____ / _____ / _________

HIPAA Consent to Discuss Your Child's Medical Information

I, ____ (print parent/guardian name) give my permission and consent to ACME Therapies and their respective consultants and agents (hereinafter collectively, the "clinic") to discuss and speak with school officials, teachers, psychiatrists, medical doctors, therapists, insurance representatives, or other professionals (collectively, "Third Party Professionals") regarding my child as such may be needed in connection with the treatment and/or evaluation of my child by the clinic. In addition, the clinic is authorized to receive any records, files, charts, and other documentation and information from such Third Party Professionals, and by signing this document, the undersigned is authorizing the release of any such information that may be held by a Third Party Professional to the clinic. Any person who is provided a copy of this document may rely on it as the undersigned's full and unconditional consent to the release of any and all information pertaining to the child. The undersigned further authorizes the clinic to release any and all information pertaining to the treatment and/or evaluation of the child to any Third Party Professional that may in any way be involved in the treatment and/or evaluation of my child. The undersigned understands that some or all of the information obtained and/or released under this document may be protected under federal regulations including but not limited to HIPAA. By authorizing a release of information, as set forth above, the undersigned understands and agrees that they are agreeing to the release of such information notwithstanding the protections under HIPAA, provided. However, it is understood and agreed that the clinic will maintain the confidentiality of any information obtained and will not disclose the same except as needed in the course of treating or evaluating the child. The undersigned, for him/herself and his or her successors and assigns, does hereby hold the clinic harmless from any and all claims relating to the release of information as provided above, and do hereby waive and release any claim against the clinic relating to the release of such information as provided above.

Parent/Guardian Signature:____Today's date:_____________

Case History Form

Please complete this form to the best of your ability, as completely as possible. This helps us identify if there are any additional areas of concern. Thank You!

Mother's Name: ____ Age: ________________________
Address: ____ Phone: _______________________
City, State, Zip: ____
Mother's Occupation: ____ Work Phone: _________________

Father's Name: ____ Age: ________________________
Address: ____ Phone: _______________________
City, State, Zip: ____
Father's Occupation: ____ Work Phone: _________________

Other's Name: ____ Age: ________________________
Address: ____ Phone: _______________________
City, State, Zip: ____
Other's Occupation: ____ Work Phone: __________________

Relationship to child:____

Brothers & Sisters (including names and ages): ____
____
____

Other Services your child may be receiving:

Is your child currently receiving home health services (nursing or therapy)? _____Yes _____No

Has your child had outpatient therapy anywhere else within this past year? _____Yes _____No

If Yes, Where? ____

Is your child receiving therapy services in school? _____Yes ______No

School:_________________________ Grade Level:______________ Teacher:_________________________

Referred by: ____ Phone: _______________________
Address: ____

Pediatrician: ____ Phone: _______________________
Address: ____

Other Doctors: ____ Phone: _______________________
Address: ____

What languages does the child speak? What is the child's primary language?

____ ____
____ ____

What languages are spoken in the home? What is the primary language spoken in the home?

____ ____
____ ____

How does your child usually communicate? (Gestures, single words, short phrases, sentences.)

Why are you bringing your child in for an evaluation? What are the problems that have been noticed? (Does not talk, cannot sit still, has a diagnosed condition, etc.)

When was the problem first noticed? By whom?

What do you think caused the problem?

Has the problem changed since it was first noticed?

Is the child aware of the problem? If yes, how does he/she feel about it?

Is your child or was your child involved in a birth-to-three/Early Intervention program?

Have any other specialists seen the child? (Physicians, psychologists, special ed teachers?) Who and when? What were their conclusions/suggestions?

Have any other therapists seen the child? (Speech, occupational or physical therapy)

Does anyone in your family have similar problems to those of the child?

PRENATAL AND BIRTH HISTORY

Mother's general health during pregnancy (illness, accidents, medications, etc.)

Length of pregnancy: ______________________________ Length of Labor: _______________________
General Condition: ________________________________ Birth Weight: _________________________

Circle type of delivery: Head first; Feet first; Breech; Caesarian

Were there any unusual conditions that may have affected the pregnancy or birth?

MEDICAL HISTORY

Please check the following illnesses and conditions your child has experienced

☐Adenoidectomy/Tonsillectomy	☐Encephalitis	☐MRSA
☐ADD/ADHD	☐ Headaches	☐Mumps
☐Allergies	☐Head Injury	☐Pneumonia
☐Asthma/Breathing Difficulties	☐High Fever	☐Psychological Problems
☐Chicken Pox	☐ High Muscle tone (hypertonia)	☐Seizures
☐Colds	☐Influenza	☐Sleeping Difficulties
☐Croup	☐Low muscle tone (hypotonia)	☐Vision Problems
☐Dizziness	☐Measles	☐Other: please list
☐Ear Infections	☐Meningitis	

Has the child had any surgeries? If yes, what type and when? (ex. Tube placement, tonsillectomy)

Describe any major accidents or hospitalizations.

Have there been any allergic reactions to medications? If yes, please list and describe.

Has the child had a hearing test? Results?

DEVELOPMENTAL HISTORY

Provide the approximate age at which the child began to do the following activities:

Crawl	Name Simple Objects (dog, car)
Sit	Use Simple Questions (where's doggie?)
Stand	Feed Self
Walk	Engage in Conversation
Use Single Words (no, mom, dog)	Dress Self
Combine Words (me go, daddy shoe)	Use Toilet

Does the child have any difficulty walking, running, or participating in other activities which require small or large muscle coordination?

Do you feel your child is excessively clumsy?

Are there or have there ever been any feeding problems (problems with sucking, swallowing, drooling, chewing, etc.). If yes, please describe.

Describe the child's response to sound (afraid of loud noises, responds to all sounds, inconsistently responds to normal sounds, covers ears with certain sounds, etc.)

Does your child require assistance with daily activities dressing, bathing/showering, use bathroom, feeding, etc.? If yes, please describe level of assistance needed.

EDUCATIONAL HISTORY

School: ____ Grade: _________________

Is this a ☐public, ☐private, ☐parochial, or ☐alternative school? Please check.

Teacher: ____

Has the child been diagnosed with any type of learning disability?

How is the child doing academically (or pre-academically)?

Does the child receive special services (IEP, PALS, etc.)?If so, please list any special education services and the amount the child receives.

If yes, please describe: How does the child interact with others (shy, aggressive, uncooperative, etc.)?

Does the child's teacher have any concerns?

SENSORY INFORMATION

Does your child tend to fall, crash, or bang into things a lot?

Does your child have a negative reaction to any of the following:

Loud noises Yes ☐ No ☐

Dirt, paint, etc. on hands Yes ☐ No ☐

Certain food textures Yes ☐ No ☐

Having teeth brushed Yes ☐ No ☐

Having hair brushed/cut Yes ☐ No ☐

Tags in clothing Yes ☐ No ☐

Wearing clothing/shoes Yes ☐ No ☐

Car sickness Yes ☐ No ☐

Being touched Yes ☐ No ☐

Does the child have a normal response to pain?

Is your child what you might call hyperactive (always moving, can't sit still)?

Does your child seem inactive (never wants to do any activity)?

ADDITIONAL INFORMATION

Please provide any additional information that might be helpful in the evaluation or remediation of the child's problem.

Person completing form: ____
Relationship to child: ____
Signature: ____ Today's Date: _____________

Please return this packet of information by e-mail, fax, or mail prior to the evaluation, if possible, so the therapists can review the child's history. If it is not possible to return this information prior to the evaluation, please bring it the day of the evaluation. On the day of the evaluation, you will need:

☐Insurance information

☐ Prescription* from the physician ordering the therapy evaluation/treatment (if MD did not fax it directly to us.)

*The child cannot be seen without a valid and current prescription.

☐ Copy of Individualized Education Plan from school (IEP) if the child has one.

☐ Copy of any evaluations done by specialists (psychologist, neurologist, etc.)

When ACME Therapies, Co. receives authorization from the child's insurance company, therapy sessions can begin. Most insurance companies will give authorization within two weeks of the initial evaluation. Thank you for taking the time to fill out this important information. Please return it to us as soon as possible: ACME Therapies Co. 128 Fayette Street Martinsville, VA 24112 or email it to ACMETherapiesco@gmail.com or fax it to us at # 276-293-1212. We look forward to working with your child!

Attendance / Cancellation Policy

At ACME Therapies, Co. we are pleased to offer you high quality therapy services. Every attempt is made to schedule your services in a timely manner and when possible, at your convenience. Regular attendance is important to achieve progress and success in therapy and it is necessary that all appointments be kept whenever possible. Because of the demand for therapy services and to ensure positive outcomes, we must enforce the following attendance policy:

Late Arrivals

- If you are more than 15 minutes late and fail to notify us, treatment may be cancelled and re-scheduled for a different day/time.

Cancellations and Reschedules:

- If you need to reschedule, please call 24 hours in advance of your appointment. Extenuating circumstances and illness will be reviewed on a case by case basis. We will make every attempt to re-schedule appointments; however we cannot guarantee a make-up appointment will be available that fits your scheduling needs. We will try to re-schedule appointments if a therapist misses work for any reason.

No Shows:

- Failure to show up for an appointment without notifying us may result in being removed from the schedule/recurring appointments. We will attempt to reach you to confirm your next appointment. However, if you do not respond to our attempts to contact you, your remaining appointments may be removed from our schedule and you may be discharged from our facility. ***You will also be charged a $20.00 No-show fee, and/or will be reported to Department of Medicaid. The NO-show fee will need to be paid prior to next scheduled service for you or your child to be treated.***

Repeated failure to comply with this attendance policy will result in your child's name being placed on a "Scheduled Based on Availability" list. This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as space on the schedule permits. We believe this policy is necessary for the benefit of all our patients, so that we may continue to provide high quality treatment and services to everyone.

All the staff at ACME Therapies appreciates your anticipated adherence and cooperation with this policy. We are here to help your child in achieving goals that will promote participation and success at school, home, and in the community.

I have read and understand the attendance policy.

Parent/Caregiver signature: ____

Today's Date:______________________

Illness Guidelines

We recognize that children at times are ill and cannot attend their scheduled therapy sessions. Please do not bring your child, or a sibling, if they are ill; he or she will not benefit from therapy and that places other children and their families at risk. If the patient or anyone accompanying them to their appointment presents with the following symptoms, please call our office as soon as possible to cancel and reschedule.

- Fever of 99.9 or higher within the last 24 hours
- Unexplained rash, blisters, ringworm, etc.
- Intestinal symptoms such as vomiting or diarrhea within the last 24 hours
- Contagious illness such as chicken pox, pink eye, strep throat, hand foot and mouth disease, etc.
- Any parasitic infestation (lice, scabies, etc.)
- Your child was too ill to attend or sent home sick from daycare or school on the day of the therapy appointment.
- Congestion and Discharge/Coughing [Difficulty Breathing that is persistent and disruptive to a therapy session.
- Extreme irritability, exhaustion, continuous crying/tantrums
- Mouth sores or wounds that are not properly covered

Your child will be able to return to their regularly scheduled therapy sessions when:

- The child has been fever-free for 24 hours.
- The child has been diagnosed/treated with an antibiotic as appropriate for 24 hours.

- It has been 24 hours since the last episode of vomiting and diarrhea.
- The ear/nasal discharge is not thick, yellow, or green.
- Eyes are no longer discharging or have been treated with an antibiotic as appropriate for 24 hours.
- The rash has subsided or a physician has determined that it is not contagious. *Doctor documentation required.
- Lice have received a scalp treatment.

Billing and Collections Policies

Copayments/Co-Insurances

______Copayments/Co-insurances are due and payable at time of service. "Routine waiver" of copayments is against the law. Therefore, in order to ensure that we comply with these regulations, we offer many convenient payment options at the time of service. We accept cash, checks or credit card payments. Returned checks will incur a $50.00 Returned Check Fee.

_____Billing Statements and Collection Policy
You are expected to pay your estimated share of therapy charges upon check-in at each visit. We will file an insurance claim for each therapy visit. After your insurance processes your insurance claims, any remaining balance not paid at the time of service will be billed to you. The balance on your Statement is due when the statement is received, and will become past due if not paid in 30 days of the statement date. If your account becomes past due, we will take necessary steps to collect this debt including sending your account to a third party collection agency.

_____Refund Policy
Once your insurance company has processed ALL claims for your therapy services, your account will be reviewed to determine any amounts in which you may have overpaid. Should you have a credit on your account, the credit amount will be refunded to you by check within 30 days from the date we receive the details for your final insurance claim from your insurance company. Please note, our company policy prohibits us from authorizing a refund before your last insurance claim has fully processed.

_____Guarantee of Payment

I authorize that the payment of my insurance benefits be made directly to ACME Therapies, Co. for any services delivered that are reimbursable by Medicare and/or my other insurance. If I am paid directly from my insurance company I will promptly pay ACME Therapies all monies paid to me. I understand that all payments designated as "patient responsibility" such as co-insurances and deductibles at the time of service or statement receipt.

I understand that should there be any change in my insurance or loss of insurance, that I may be expected to pay for my care at the allowed amount or at the current cash rate.

Parent/Guardian Signature:____

Today's Date:_____________________

128 Fayette Street • Martinsville, VA 24112

Office Phone: 276-224-5297 • Office Cell: 276-352-4465

NOTICE ON LATE/NO SHOW APPOINTMENTS:

- Cancellations **MUST** be made 24 hours in advance by calling or texting the office numbers above.
- Please do NOT text your/your child's therapist to cancel without letting the office know **FIRST**, by promptly calling front office or sending a text to 276-224-5297.
- If cancellation is not made 24 prior to appointment, it will be considered a "**no show**".
- Please arrive at least 5 minutes early for your/your child's appointment.
- Parents: please arrive at least 5 minutes prior to appointment end time so the therapist has time to go over your child's session with you. Our appointments are scheduled back to back, so if you arrive at the session end time, the therapist may not be able to speak with you.
- If you are unable to make your appointment in person for any reason and are interested in doing teletherapy via facetime, zoom, facebook messenger etc, please reach out to the office.
- If you do not currently receive text message reminders for your child's appointments, please see the front office to sign up or fill out the information below:
  Cell Phone Number (s) for reminders: ____
  Cell Phone Carrier: ____

Failure to comply with the appointment policy may result in reduction or termination of your/your child's therapy sessions. Please sign below to confirm to have read and agree to the policies listed. Thank you.

Patient Name (printed): ____

Patient Signature (Parent, Guardian): ____

Today's Date: _______________________________

Marketing Participant Release Form

The undersigned hereby transfers and assigns ACME Therapies Co. the exclusive right to use and to authorize others to use all or any part of his/her image or interview (as recorded on photographic means, videotape, audiotape, or in other electronic formats) in the program, article, or commercial on:

____

The undersigned also hereby transfers and assigns to ACME Therapies Co. the right to use and authorize others to use all or any part of his/her image or interview (as described above) in related media such as books, magazines, journals, pamphlets, and other written, video and computer formats.

Printed name of Participant ____

Participant Date of Birth _____________________

Signature of Participant ____________________________________ Date ______________________

If a participant is under 18 years of age, this form should be signed by a parent or guardian.

Signature of guardian ______________________________________ Date______________________