Beelieve
PEDIATRIC THERAPY

New Patient Paperwork

10932 Old Denton Road
Suite 112
Fort Worth, TX 76244
Phone: 817-431-9000
Fax: 817-796-2781

PATIENT INFORMATION

FULL NAME: _____

SEX: □ **Male** □ **Female** BIRTHDATE: _____ AGE: _____

PATIENTS PRIMARY ADDRESS: _____

_____

LEGAL GUARDIANS NAME (S): _____

CELL PHONE (MOM): _____ (DAD): _____

PRIMARY EMAIL ADDRESS: _____

EMERGENCY CONTACT (OTHER THAN MOM AND DAD): _____

PHONE NUMBER: _____ RELATIONSHIP TO PATIENT: _____

CAREGIVERS NAME (IF APPLICABLE) : _____ CONTACT #:_____

REMINDERS CIRCLE PREFERNCE: CALL TEXT EMAIL (if text who is your carrier?): _____

INSURANCE INFORMATION

(PRIMARY INSURANCE)

INSURED'S FULL NAME: _____BIRTHDATE: _____

ADDRESS (IF DIFFERENT THAN PATIENT): _____

EMPLOYER NAME: _____

INSURANCE COMPANY: _____

PRIMARY ID #: _____ POLICY/GROUP #: _____

(SECONDARY INSURANCE)

INSURED'S FULL NAME: _____BIRTHDATE: _____

INSURANCE COMPANY: _____

PRIMARY ID #: _____ POLICY/GROUP #: _____

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PATIENT QUESTIONNAIRE

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BIRTH HISTORY

Was child born full term? _____ If not, how many weeks? _____
Were there any complications at birth? _____

_____

Did the child spend any time in the NICU? If so, how long? _____
Did the child require oxygen? _____ For how long? _____
Length of time in the hospital: _____

MEDICAL INFORMATION

Medical diagnoses: _____

_____

Does the patient have any allergies? _____
Current medications: _____

_____

Primary care doctor: _____
Referring doctor: _____
Specialists seen: _____
Hospitalizations/Surgeries: _____

_____

_____

Equipment: _____

_____

THERAPY SPECIFIC INFORMATION

At what age did your child roll? _____ Sit alone? _____
Crawl? _____ Walk? _____
Say first word? _____ Put 2 words together? _____
Does your child wear glasses? _____ Vision issues? _____

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Does your child have any hearing issues? _____

Does your child startle easily? _____

What kind of food does your child eat? □ Puree □ Soft textures □ Regular diet □ Tube fed

Does your child refuse to eat any foods? _____

Is your child's language understood by: parents? _____ Siblings? _____

Teachers? _____ Peers? _____

OTHER

Who lives in the home with the patient?: _____

Does the patient live in two homes?: _____

Is your child in school? _____ What grade? _____

Name of school _____

Does your child receive therapy in school? _____

Name of therapist(s) _____

Is your child in a mainstream classroom? _____

Does your child have trouble with reading? _____ Handwriting? _____

Does your child receive any other therapy at this time? _____

If so, what disciplines and with whom? _____

_____

What are you most wanting to get out of therapy for your child?: _____

_____

TELL US A FEW OF HIS/HER FAVORITES

Favorite color: _____

Favorite character: _____

Favorite toy: _____

Favorite food: _____

Favorite candy: _____

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PATIENT AUTHORIZATION RECORD

Patient Name: _____ **Date:** _____

Initial	Policies/Consents/Authorizations
	Authorization for Treatment ❖ I hereby authorize and give consent to *Beelieve Pediatric Therapy Clinic* and its staff to evaluate and treat as they deem appropriate according to the practice guidelines of the American Physical Therapy Association (APTA), American Occupational Therapy Association (AOTA), American Speech-Language-Hearing Association (ASHA) and the state of Texas. ❖ I acknowledge that there is some risk inherent in the use of the therapy equipment and I agree to assume such risk and indemnify and hold *Beelieve Pediatric Therapy* and its staff, harmless from any and all losses and claims for any injuries or other damages occurring to myself, my child(ren) or our belonging.
	Authorization for Release of Information ❖ I authorize *Beelieve Pediatric Therapy Clinic* to release medical information necessary for my medical care to insurance companies and Medicaid (Cooks StarKids, CHIP, Aetna Medicaid and CHIP). to obtain payment for services rendered. ❖ I authorize *Beelieve Pediatric Therapy Clinic* to release medical information to physicians, child's school or anyone who needs this medical information regarding the care of my child. ❖ I agree that *Beelieve Pediatric Therapy Clinic* may obtain information from others who have provided medical care to my child and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. This includes, but is not limited to: physicians, insurance companies, other therapists, and employees at child's school. ❖ I authorize *Beelieve Pediatric Therapy Clinic* to contact any of my child's therapists (school and private therapists) in order to coordinate care and obtain necessary medical information. ❖ I have read "Notice of Privacy Practices" mandated by HIPAA. ❖ It is *Beelieve Pediatric Therapy Clinic's* policy to protect all medical records against loss, tampering, defacement and use by unauthorized persons. Safeguards are in place to protect the confidentiality of protected health information.
	Authorization for Release of payment ❖ I authorize that direct payment of any benefits available to me be released to *Beelieve Pediatric Therapy Clinic* for services rendered.
	Emergency Medical Treatment Release ❖ In the event of an emergency situation, I give the staff of *Beelieve Pediatric Therapy Clinic* my permission to initiate emergency medical services for my child listed if I am not present during the emergency. ❖ My hospital preference is _____, however I acknowledge that *Beelieve Pediatric Therapy Clinic* will not be held responsible for hospital or EMS providers designated. ❖ I authorize *Beelieve Pediatric Therapy Clinic* to release client records upon request to the authorized individual or agency involved in emergency medical care.

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	Patient Financial Agreement ❖ *Beelieve Pediatric Therapy Clinic* is in a relationship with you, the patient, and not your insurance company. While we do file insurance claims as a courtesy, **all charges are ultimately the patient's responsibility**. The primary policy holder of insurance will be responsible for all payments. ❖ I agree to pay *Beelieve Pediatric Therapy Clinic* for services rendered to me during my course of treatment. An "estimated amount" will be collected at each visit, due to each insurance plan reimbursing at a slightly different rate. **I agree to pay what my insurance company does not cover.** ❖ I agree to pay deductibles, copayments or any other charges, which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay *Beelieve Pediatric Therapy Clinic* collections costs including attorney and court fees. ❖ I agree to be responsible for my deductible. If I have hit my deductible via other medical expenses, but claims returned from my insurance show I have not, I understand I will be responsible for paying the difference. ❖ I have been informed of my financial responsibilities for treatment provided to me (or my child) by *Beelieve Pediatric Therapy Clinic*. ❖ If I have a financial hardship I will discuss this with the staff of *Beelieve Pediatric Therapy Clinic*, before treatment begins, to set up a payment plan.
	Attendance/Cancellation Policy ❖ During therapy sessions, I agree to stay within a 15-mile radius and **return to clinic at least 5 minutes before my child's session is scheduled to be finished**. ❖ *Beelieve Pediatric Therapy* and its staff are only responsible for my child during my child's scheduled therapy session time. ❖ It is the patient's responsibility to make every effort to **attend all therapy sessions**. ❖ If the patient is sick, we expect a call to cancel visit as soon as possible. We will try to reschedule visit within the same month. We require them to be fever free for 24-hours, and if they are hospitalized we need a note from the Doctor to resume therapy. ❖ *Beelieve Pediatric Therapy Clinic* has a 24-hour cancellation policy. A $30 missed visit fee will be assessed after one warning and will be collected at next session.
	Personal Relationships Medical Release: I authorize that Beelieve Pediatric Therapy can release medical information, days and times of appointments, and billing information to the following individuals: Name:_____ Contact #:_____ DOB:_____ Name:_____ Contact #:_____ DOB:_____ Name:_____ Contact #:_____ DOB:_____

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Pick up/Drop off Release:

I authorize Beelieve Pediatric Therapy to allow the following individuals to pick up and drop off my child. I understand that the individuals will need to have a photo ID on them for verification.

Name:_____ Contact #:_____ DL:_____

Name:_____ Contact #:_____ DL:_____

Name:_____ Contact #:_____ DL:_____

Photo/Video Release:

- I grant Beelieve Pediatric Therapy Clinic, its representative and employees the right to take photographs or video of my child/children listed above. I authorize Beelieve Pediatric Therapy Clinic, its assigns and transferees to copyright, use and publish the same in print and/or electronically.
- They may use such photographs of my child/children with or without name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising and web content
- They may use photos of my child and highlight my child's accomplishment in the front office, waiting are and throughout the clinic

I, _____ have read all the above stated policies and understand the contents in them. I consent to treatment by the staff at *Beelieve Pediatric Therapy Clinic*. I agree to be responsible for my child's therapy and will be responsible for any fees associated with my inability to adhere to the 24-hour cancellation policy.

_____ _____

Parent/Legal Guardian signature Date